

Retiree Enrollment Guide

Your PEBB Benefits for 2015

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This booklet contains information you need about benefits, monthly premiums, and the plans available to you.

Important requirements to remember:

- You have 60 days after the date your employer-paid or continuous COBRA coverage ends to enroll in or defer (postpone) PEBB retiree coverage. If the PEBB Program doesn't receive your completed *Retiree Coverage Election/Change* form within the required timeframe, you could lose your right to enroll.
- If you wish to enroll family members on your PEBB retiree insurance coverage, you must provide documents that verify their eligibility within PEBB's timelines, or they will not be enrolled. This applies to retirees not entitled to Medicare Part A and B, and any retiree enrolling a registered domestic partner.
- If entitled, you and/or your family member(s) must enroll and maintain enrollment in both Medicare Part A and Part B to qualify for PEBB retiree coverage. If you don't, you and/or your family member(s) will no longer be eligible for enrollment in PEBB retiree coverage.
- We will not enroll you until we receive your first premium payment unless you choose to have your premiums deducted from your monthly pension check.

If you want additional information about Public Employees Benefits Board (PEBB) coverage

Call the PEBB Program at 360-725-0440 or toll-free at 1-800-200-1004, Monday through Friday, 8 a.m. to 5 p.m. For personal assistance, visit our office at 626 8th Avenue SE, Olympia, WA, 98501. To send a fax, dial 360-725-0771. Go to www.hca.wa.gov/pebb for forms, publications, and information updates.

Mail first premium payments to:

Health Care Authority
P.O. Box 42695
Olympia, WA 98504-2695

Write to the PEBB Program at:

Health Care Authority
P.O. Box 42684
Olympia, WA 98504-2684

For automatic bank account withdrawals of your monthly premium:

An *Electronic Debit Service Agreement* form is provided in the back of this booklet.

To obtain this document in another format (such as Braille or audio), call 1-800-200-1004. TTY users may call through the Washington Relay service by dialing 711.

Contact Information

| Contact the health plans for help with: | Contact the PEBB Program at 1-800-200-1004 for help with: |
|--|---|
| <ul style="list-style-type: none"> • Specific benefit questions. • Verifying if your doctor or other provider contracts with the plan. • Verifying if your medications are listed in the plan's drug formulary. • ID cards and claims. | <ul style="list-style-type: none"> • Eligibility questions and changes (Medicare, divorce, etc.). • Changing your name, address, or phone number. • Adding or removing dependents. • Finding forms. • Eligibility complaints or appeals. |

| Medical plans | Website addresses | Customer service phone numbers | TTY customer service phone numbers |
|--|--|--|------------------------------------|
| Group Health Classic, Medicare, or Value | www.ghc.org/pebb | 206-901-4636 or 1-888-901-4636 | 711 or 1-800-833-6388 |
| Group Health Options Inc. (CDHP) | www.ghc.org/pebb | 206-901-4636 or 1-888-901-4636 | 711 or 1-800-833-6388 |
| Kaiser Permanente Classic, CDHP, or Senior Advantage | www.my.kp.org/nw/wapebb | 503-813-2000 or 1-800-813-2000 Medicare members: 1-877-221-8221 | 711 |
| Medicare Supplement Plan F, administered by Premiera Blue Cross | www.premera.com | 1-800-817-3049 | 1-800-842-5357 |
| Uniform Medical Plan Classic or CDHP, administered by Regence BlueShield | www.hca.wa.gov/ump | 1-888-849-3681 | 711 |

| Dental plans | Website addresses | Customer service phone numbers |
|---|--|--------------------------------|
| DeltaCare, administered by Delta Dental of Washington | www.deltadentalwa.com/pebb | 1-800-650-1583 |
| Uniform Dental Plan, administered by Delta Dental of Washington | www.deltadentalwa.com/pebb | 1-800-537-3406 |
| Willamette Dental of Washington, Inc. | www.WillametteDental.com/WApebb | 1-855-433-6825 |

Additional contacts

| | | | |
|--|----------------------------------|--|---|
| Health savings account | HealthEquity, Inc. | www.healthequity.net/pebb | 1-877-873-8823 TTY: 711 |
| VEBA, Voluntary Employee Beneficiary Association Trust | Meritain Health | www.veba.org | 1-888-828-4953 |
| SmartHealth | Limeade | www.smarthealth.hca.wa.gov (available January 2, 2015) | 1-855-750-8866 (available January 2, 2015) |
| Life insurance | ReliaStar Life Insurance Company | www.hca.wa.gov/pebb/pages/life_retired.aspx | 1-866-689-6990 |
| Auto and home insurance | Liberty Mutual Insurance Company | www.hca.wa.gov/pebb/pages/auto_home.aspx | 1-800-706-5525 |

PEBB Program is Saving the Green

Help reduce our reliance on paper mailings — and their toll on the environment — by signing up to receive PEBB mailings by email. To sign up, go to www.hca.wa.gov/pebb and select *My Account* under the My PEBB header in the left navigation panel.



Welcome to Retirement!

The Public Employees Benefits Board (PEBB) Program, administered by the Health Care Authority (HCA), is pleased to offer continued choice, access, value, and stability in benefits. The PEBB Program purchases and coordinates health insurance benefits for eligible public employees and retirees, so you can expect to receive competitive benefits from one of the largest health care purchasers in the state.

Who determines the benefits?

The Legislature establishes how much state money is available to spend on benefits. Then the PEB Board establishes eligibility requirements and approves benefit designs for insurance and other benefits. The Board meets regularly to review benefit and eligibility issues, and plan for the future.

Who purchases the benefits?

The HCA purchases benefits within the funding approved by the Legislature. The HCA contracts with insurance companies and manages its own self-insured plans, the Uniform Medical Plan and Uniform Dental Plan, to provide a choice of quality health care options and responsive customer service to its members.

Inside this booklet you will find ...

- Information on who can enroll.
- Enrollment requirements.
- Monthly premiums.
- Basic information about your medical and dental coverage, life, and auto and home insurance options.
- Plans available in your county.

The benefits comparisons in this guide are brief summaries. For more details about a plan's benefits, refer to the plan's certificate of coverage. You may request a copy of the certificate of coverage from your health plan after you enroll, or you can find it on the plan's website. Some information described in this guide is based on federal or state laws. We have attempted to describe them accurately but if there are differences the laws will govern.

The contents of this booklet are accurate at the time of printing. You may call the PEBB Program at 1-800-200-1004 for questions on eligibility or enrollment and you can go to www.hca.wa.gov/pebb for updates to laws or rules or to find more information. If you have questions not answered in this booklet, you can reach a benefits representative Monday through Friday between 8 a.m. and 5 p.m. Pacific Time.

Where to find laws and rules

You can find the Public Employees Benefits Board's existing law in chapter 41.05 of the Revised Code of Washington, and rules in chapters 182-04, 182-08, 182-12, 182-13, and 182-16 of the Washington Administrative Code (WAC). A link to WAC is available on the *PEBB Rules and Policies* page of the PEBB website.

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2015 Retiree Monthly Premiums

Effective January 1, 2015

Special Requirements

1. To qualify for the Medicare rate, at least one covered family member must be enrolled in both Part A and Part B of Medicare.
2. Medicare-enrolled subscribers in Group Health Cooperative's Medicare Advantage plan or Kaiser Permanente Senior Advantage must complete and sign the *Medicare Advantage Plan Election Form* (form C) to enroll in one of these plans. For more information on these requirements, contact your health plan's customer service department.

| Medical Plans | | | | | | | |
|---|----------------------|--------------------|-------------------|---------------------------|------------------------|-------------|-----------|
| Members not eligible for Medicare (or enrolled in Part A only): | Group Health Classic | Group Health Value | Group Health CDHP | Kaiser Permanente Classic | Kaiser Permanente CDHP | UMP Classic | UMP CDHP |
| Subscriber Only | \$ 600.80 | \$ 569.38 | \$ 530.10 | \$ 619.65 | \$ 540.35 | \$ 578.51 | \$ 535.82 |
| Subscriber and Spouse* | 1,195.35 | 1,132.51 | 1,044.74 | 1,233.05 | 1,064.74 | 1,150.77 | 1,056.18 |
| Subscriber and Child(ren) | 1,046.71 | 991.73 | 930.66 | 1,079.70 | 948.23 | 1,007.71 | 940.67 |
| Full Family | 1,641.26 | 1,554.86 | 1,386.97 | 1,693.10 | 1,414.29 | 1,579.97 | 1,402.70 |

| Members enrolled in Part A and Part B of Medicare: | Group Health Medicare Plan | Group Health Classic | Group Health Value | Kaiser Permanente Classic | UMP Classic |
|--|----------------------------|----------------------|--------------------|---------------------------|-------------|
| Subscriber Only | \$ 148.14 | N/A† | N/A† | \$ 153.02 | \$ 234.69 |
| Subscriber and Spouse* (1 Medicare eligible) | N/A† | \$ 742.69 | \$ 711.27 | 766.42 | 806.95 |
| Subscriber and Spouse* (2 Medicare eligible) | 290.03 | N/A† | N/A† | 299.79 | 463.13 |
| Subscriber and Child(ren) (1 Medicare eligible) | N/A† | 594.05 | 570.49 | 613.07 | 663.89 |
| Subscriber and Child(ren) (2 Medicare eligible) | 290.03 | N/A† | N/A† | 299.79 | 463.13 |
| Full Family (1 Medicare eligible) | N/A† | 1,188.60 | 1,133.62 | 1,226.47 | 1,236.15 |
| Full Family (2 Medicare eligible) | N/A† | 735.94 | 712.38 | 759.84 | 892.33 |
| Full Family (3 Medicare eligible) | 431.92 | N/A† | N/A† | 446.56 | 691.57 |

* or registered domestic partner

† If a Group Health subscriber is enrolled in Medicare Part A and Part B but covers a family member not eligible for Medicare, the family member must enroll in a Group Health Classic or Value plan and the subscriber pays a combined Medicare and non-Medicare rate.

Medicare Supplement Plan F, administered by Premera Blue Cross

| | Plan F (Age 65 or older, eligible by age) | Plan F (Under age 65, eligible by disability) |
|---|--|--|
| Subscriber Only | \$ 110.08 | \$ 209.26 |
| Subscriber and Spouse* (1 Medicare eligible)† | 682.34 | 781.52 |
| Subscriber and Spouse* (2 Medicare eligible – 1 retired, 1 disabled) | 313.09 | 313.09 |
| Subscriber and Spouse* (2 Medicare eligible) | 213.91 | 412.27 |
| Subscriber and Child(ren) (1 Medicare eligible)† | 539.28 | 638.46 |
| Full Family (1 Medicare eligible)† | 1,111.54 | 1,210.72 |
| Full Family (2 Medicare eligible – 1 retired, 1 disabled)† | 742.29 | 742.29 |
| Full Family (2 Medicare eligible)† | 643.11 | 841.47 |

* or registered domestic partner

† If a Medicare supplement plan is selected, non-Medicare eligible dependents are enrolled in the Uniform Medical Plan (UMP) Classic. The rates shown reflect the total due, including premiums for both plans.

Medicare rates shown above have been reduced by the state-funded contribution up to the lesser of \$150 or 50 percent of plan premium per retiree per month.

Monthly Premium Surcharges

The following surcharges may be billed in addition to the medical plan premiums due from subscribers.

These surcharges do not apply if the subscriber is enrolled in Medicare Part A and Part B.

- A monthly \$25 surcharge will apply if the subscriber or one or more of the enrolled family members use tobacco products.
- A monthly \$50 surcharge will apply if a subscriber enrolls a spouse or registered domestic partner, and the spouse or partner has chosen not to enroll in medical coverage through his or her employer-based group medical insurance that is comparable to Uniform Medical Plan (UMP) Classic.

| Dental Plans with Medical Plan | DeltaCare, administered by Washington Dental Service | Uniform Dental Plan, administered by Washington Dental Service | Willamette Dental of Washington, Inc. |
|-----------------------------------|---|---|--|
| Subscriber Only | \$ 39.53 | \$ 45.22 | \$ 42.37 |
| Subscriber and Spouse* | 79.06 | 90.44 | 84.74 |
| Subscriber and Child(ren) | 79.06 | 90.44 | 84.74 |
| Full Family | 118.59 | 135.66 | 127.11 |

* or registered domestic partner

Retiree Life Insurance Self-Pay Rate – \$7.78 per month

Eligibility Summary

Who is eligible for PEBB coverage?

This guide provides a general summary of PEBB retiree eligibility. The PEBB Program will determine your eligibility based on when your application is received and PEBB rules. If you disagree with the determination, see “How can I appeal a decision?” on page 11.

You may be eligible to enroll in PEBB plans if you are a retiring employee of a:

- State agency.
- State higher education institution.
- Washington State school district or educational service district.
- PEBB-participating employer group.

You may also be eligible to enroll in PEBB retiree insurance if you are an elected or full-time appointed state official (as defined under WAC 182-12-114(4)) who voluntarily or involuntarily leaves public office.

To be eligible to enroll in PEBB retiree insurance, you must meet both the procedural requirements and the eligibility requirements of WAC 182-12-171.

Procedural requirements include:

- You must submit a *Retiree Coverage Election/Change* form (form A) to enroll or defer enrollment in retiree insurance coverage. The PEBB Program must receive the form **no later than 60 days** after your employer-paid or COBRA coverage ends.
- If you or a dependent you wish to enroll is entitled to Medicare and your retirement date is after July 1, 1991, you must enroll in and maintain enrollment in Medicare Part A and Part B.
- If you do not enroll in PEBB retiree coverage at retirement or separation from service, you are only eligible to enroll at a later date if you defer enrollment and maintain continuous enrollment in other qualifying insurance coverage as described in WAC 182-12-200 and 182-12-205. See important information about deferring retiree insurance coverage on page 18.

In general, the eligibility requirements are:

You must be a vested member and meet the eligibility criteria to retire from a Washington State-sponsored retirement plan when your employer-paid or COBRA coverage ends (unless you are an elected or appointed state official as defined under WAC 182-12-114(4)). The following are Washington State-sponsored retirement plans:

- Public Employees' Retirement System (PERS) 1, 2, or 3
- Public Safety Employees' Retirement System (PSERS) 2
- Teachers Retirement System (TRS) 1, 2, or 3
- Washington Higher Education Retirement Plan (for example, TIAA-CREF)
- School Employees' Retirement System (SERS) 2 and 3
- Law Enforcement Officers' and Fire Fighters' Retirement System (LEOFF) 1 or 2
- Washington State Patrol Retirement System (WSPRS) 1 or 2
- State Judges/Judicial Retirement System
- Civil Service Retirement System and Federal Employees' Retirement System are considered a Washington State-sponsored retirement system for Washington State University Extension employees covered under PEBB insurance at the time of retirement or disability.

You must immediately begin to receive a monthly retirement plan payment, with the following exceptions:

- If you receive a lump sum payment instead of a monthly retirement plan payment, you are only eligible if the Department of Retirement Systems offered you the choice between a lump sum equivalent payment and an ongoing monthly payment.
- If you are an employee retiring or separating under PERS Plan 3, TRS Plan 3, or SERS Plan 3, and you meet the retirement plan's eligibility criteria, you do not have to receive a monthly retirement plan payment to enroll in retiree insurance coverage.
- If you are an employee retiring under a Washington State higher education retirement plan (such as TIAA-CREF) and you meet your retirement plan's eligibility criteria or you are at least age 55 with 10 years of state service, you do not have to receive a monthly retirement plan payment.

- If you are an employee retiring from a PEBB-participating employer group and your employer does not participate in a Washington State-sponsored retirement system, you do not have to receive a monthly retirement plan payment. However, you do have to meet the same age and years of service as if you had been employed as a member of either PERS Plan 1 or PERS Plan 2 for the same period of employment.
- If you are an elected or full-time appointed official of the legislative or executive branches of state government (as defined under WAC 182-12-114(4)), you do not have to meet the age and years of service requirement or receive a monthly retirement plan payment from a state-sponsored retirement system.

Can I cover my family members?

You may enroll the following family members (as described in WAC 182-12-260):

- Your lawful spouse.
- Your registered domestic partner. Effective January 1, 2010, this includes a state-registered domestic partner, or a domestic partner who qualified under PEBB eligibility criteria as a domestic partner before January 1, 2010, and was continuously enrolled in your PEBB health plan or PEBB life insurance.
- Your children up to age 26, except as described below for children with a disability.
- Children are defined as your biological children, stepchildren, legally adopted children, children for whom you have assumed a legal obligation for total or partial support in anticipation of adoption, children of your registered domestic partner, children specified in a court order or divorce decree, or children defined in Washington State statutes that establish the parent-child relationship.

In addition, children include extended dependents in your, your spouse's, or your registered domestic partner's legal custody or legal guardianship. An extended dependent may be your grandchild, niece, nephew, or other child for whom you, your spouse, or registered domestic partner have legal responsibility

as shown by a valid court order and the child's official residence with the custodian or guardian. This does not include foster children for whom support payments are made to you through the state Department of Social and Health Services (DSHS) foster care program.

Eligible children also include children of any age with a developmental disability or physical handicap that renders the child incapable of self-sustaining employment and chiefly dependent upon the employee for support and ongoing care, provided the condition occurred before age 26. You must provide evidence of the disability and evidence the condition occurred before age 26. The PEBB Program or its contracted medical plans will verify the disability and dependency of a child with a disability periodically beginning at age 26.

A child with a developmental disability or physical handicap who becomes self-supporting is not eligible as a child as of the last day of the month he or she becomes capable of self-support. If the child becomes capable of self-support and later becomes incapable of self-support, the child does not regain eligibility as a child with a disability.

If adding an extended dependent or a dependent with a disability, you must complete and submit the appropriate dependent certification form in addition to your enrollment form. You can find the forms and instructions on how to submit them at www.hca.wa.gov/pebb.

In certain cases, an individual may be eligible for enrollment as a spouse, registered domestic partner, or child according to Washington State statutes recognizing legal unions.

The PEBB Program verifies the eligibility of all dependents and will request proof of a dependent's eligibility. The PEBB Program will not enroll a dependent if the PEBB Program cannot verify the dependent's eligibility. You can find a list of documents you must provide to verify your dependent's eligibility on page 46.

You must notify the PEBB Program when your dependent is no longer eligible. The PEBB Program must receive notice **no later than 60 days** after your dependent is no longer eligible.

(continued)

Eligibility Summary

If I die, do my surviving dependents remain eligible for benefits?

As an eligible employee or retiree, your surviving spouse, registered domestic partner, or child may be eligible to enroll in PEBB retiree insurance if they meet both eligibility and procedural requirements outlined in WAC 182-12-265.

When are dependents of emergency service employees eligible?

If you are a surviving spouse, state-registered domestic partner, or dependent child of an emergency service employee who was killed in the line of duty, you may be eligible to enroll in PEBB retiree insurance if you meet both the procedural and eligibility requirements outlined in WAC 182-12-250.

PEBB Appeals

How can I appeal a decision?

If you or your dependent disagrees with a PEBB denial notice, you or your dependent may file an appeal. Submit your appeal one of the following ways:

Mail: PEBB Appeals Manager
Washington State Health Care Authority
P.O. Box 42699
Olympia, WA 98504-2699

Email: pebappeals@hca.wa.gov

FAX: 360-725-0771

You will find guidance on filing an appeal in chapter 182-16 WAC and at www.hca.wa.gov/pebb or you can contact the PEBB appeals manager at 1-800-351-6827 or by email.

How can I make sure my personal representative has access to my health information?

You must provide us with a copy of a valid power of attorney or a completed *Authorization for Release of Information* form naming your representative and authorizing him or her to access your medical records and exercise your rights under the federal HIPAA privacy rule. HIPAA stands for the Health Insurance Portability and Accountability Act of 1996. The form is available at www.hca.wa.gov/pebb/pages/forms.aspx or by calling the PEBB Program at 1-800-200-1004.

| If you are... | ...and your appeal concerns: | You must: |
|--|---|---|
| <ul style="list-style-type: none">• A retiree or a retiree's dependent• A survivor of a deceased employee or retiree as described in WAC 182-12-265, or the survivor's dependent• A survivor of emergency service personnel killed in the line of duty as described in WAC 182-12-250, or the survivor's dependent• The dependent of one of the above | A denial notice from the PEBB Program about eligibility for benefits, enrollment, premium payments, or eligibility to participate in the PEBB wellness program (SmartHealth) or receive a wellness incentive. | Submit your appeal to the PEBB appeals manager. The appeals manager must receive your appeal no later than 60 days after the date of the PEBB Program's denial notice you are appealing. Send appeals as directed above. |
| | A decision or action by a health plan, insurance carrier, or third-party administrator about a claim or benefit (such as a dispute about a course of treatment or billing), completion of the PEBB wellness program (SmartHealth) requirements, or a request for a reasonable alternative to a PEBB wellness program requirement. | Contact the health plan, insurance carrier, or third-party administrator to request information on how to appeal its decision or action. |
| | A third-party administrator's decision about your appeal regarding completion of wellness program requirements or a request for a reasonable alternative to a wellness program requirement. | Submit your appeal to the PEBB Appeals Manager. The Appeals Manager must receive your appeal no later than 60 days after the date of the third-party administrator's denial notice. Send appeals as directed above. |

New Enrollment

How do I enroll?

It's important to submit your forms within the required timelines. As noted in the "Eligibility Summary," the PEBB Program must receive your *Retiree Coverage Election/Change* form (form A) indicating your decision to enroll or defer **no later than 60 days** after your employer-paid or COBRA coverage ends. If you miss that 60-day window, you lose all rights to enroll in PEBB retiree coverage in the future unless you regain eligibility. To regain eligibility, you would have to return to work in a PEBB or Washington State school district or educational service district benefits-eligible position and, at the time of termination, meet the enrollment and eligibility requirements of WAC 182-12-171.

Submit your completed *Retiree Coverage Election/Change* form (form A) and any other required forms, to the PEBB Program as instructed on the form (found in the back of this guide). You must submit form A even if you decide to defer (postpone) your enrollment. See "Deferring Your Coverage" on page 18 for more information.

Include any eligible dependents you wish to enroll on the form(s). If you are a retiree who is not enrolled in Medicare Part A and Part B, or adding a registered domestic partner, you must provide proof of your dependents' eligibility within the PEBB Program's enrollment timelines or the family members will not be enrolled. See page 46 for a list of documents required to verify dependents.

If the Department of Retirement Systems (DRS) determines that you are retroactively eligible for a pension benefit due to disability, or the appropriate higher education authority determines that you are retroactively eligible for a supplemental retirement plan benefit under the Higher Education Retirement Plan due to disability, you may either enroll retroactive to the date of eligibility for retirement, or prospective from the date on the determination letter sent to you.

You must send your first premium payment when you enroll, unless you choose to have your premiums and any applicable surcharges deducted from your monthly pension check. Make your check payable to the Health Care Authority.

If you enroll, you must pay premiums (and any applicable surcharges) back to the date when your other coverage ended. For example, if your other coverage ends in December, but you don't submit your enrollment form until February, you must pay January and February premiums and applicable surcharges to enroll in PEBB coverage.

Can I enroll on two PEBB accounts?

If you and your spouse or registered domestic partner are both independently eligible for PEBB coverage, you need to decide which of you will cover yourselves and any eligible children on your medical or dental plans. An enrolled family member may be enrolled in only one medical or dental plan. For example, you could defer PEBB retiree medical coverage for yourself (see "Deferring Your Coverage" on page 18) and enroll as a dependent on your spouse's or registered domestic partner's medical coverage.

What can I expect after I submit my enrollment form?

If you are retiring as a state employee or a higher-education institution employee, your retiree health coverage will begin on the first day of the month after your employer-paid or COBRA coverage ends.

These are the steps that will occur:

1. In most cases, your employer's payroll office will cancel your employee coverage when they process your final paycheck. We cannot enroll you in retiree coverage until this occurs.
2. The health plan(s) that covered you as an employee will send you a cancellation letter after your payroll office cancels your employee coverage. Federal rules require us to send you a *PEBB Continuation of Coverage Election Notice* booklet; keep it for future reference.
3. If your application is incomplete, we will send you a letter requesting more information. In most cases, your retiree coverage begins immediately after your current coverage ends.

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4. Once your payroll office cancels your employee coverage and we receive any requested additional information, we will enroll you in PEBB retiree health coverage.
 5. After we enroll you, your health plan(s) will send you a welcome packet.

If you are a Washington State school district or educational service district retiree and meet PEBB eligibility and enrollment requirements, your coverage begins the first of the month after your school district or COBRA coverage ends.

Paying for Benefits

How much do the plans cost?

The cost for your health benefits depends on which medical or dental plan you select. Premiums start on page 6. In addition to your monthly premium, you must pay for any deductibles, coinsurance, or copayments under the plan you choose. See the certificate of coverage or *Summary of Benefits and Coverage* available from each plan.

The HCA collects premiums for the full month, and will not prorate them for any reason, including when a member dies before the end of the month. You may not have a gap in coverage so your first payment for premiums will be retroactive to the first of the month after your other coverage ends.

Some subscribers must also pay a premium surcharge:

- A monthly \$25 surcharge will apply if you or one of your enrolled family members uses tobacco products.
- A monthly \$50 surcharge will apply if you enroll your spouse or registered domestic partner, and the spouse or partner has chosen not to enroll in other employer-based group medical insurance that is comparable to Uniform Medical Plan Classic.

These surcharges will not apply if the subscriber is enrolled in Medicare Part A and Part B.

How do I pay for coverage?

You can help ensure that your premium payments are made on time and avoid disruptions in your coverage by using pension deduction through the Department of Retirement Systems (DRS) or automatic bank account withdrawals. Here are your payment options:

- DRS pension deduction — Your premium and any applicable surcharges are taken from your end-of-the-month pension check. For example, if your coverage takes effect January 1, your January 31 check will show your deductions for January.
- Automatic bank account withdrawals — You must complete and return the *Electronic Debit Service Agreement* form to the HCA. You can find the form in the back of this booklet. Approval takes six to eight weeks, so you must continue to pay the total due shown on your invoices until you receive a letter from the HCA with your electronic debit start date.

- A personal check or money order — Please make your check payable to Health Care Authority and send it with your *Retiree Coverage Election/Change* form to:

Health Care Authority
P.O. Box 42695
Olympia, WA 98504-2695

Can I use a VEBA account?

If you have a Voluntary Employees' Beneficiary Association Medical Expense Plan (VEBA MEP) account, you can set up a systematic withdrawal to reimburse your qualified insurance premiums. The VEBA MEP does not pay your monthly premiums directly to the PEBB Program.

Qualified insurance premiums include medical, dental, vision, Medicare supplement, Medicare Part B, Medicare Part D, and tax-qualified long-term care insurance (subject to annual IRS limits). Retiree term-life insurance premiums are not eligible for reimbursement from your VEBA MEP account.

Note: It is important that you notify the VEBA MEP when your premiums change or if you become rehired by the employer that contributed to your account. Qualified medical care expenses and premiums you incur while you are re-employed by the employer that contributed to your account are not eligible for reimbursement from your account. Also, if you enroll in a consumer-directed health plan (CDHP), you must elect "limited purpose" VEBA MEP coverage.

More information and participant forms, including the *Systematic Premium Reimbursement Form* and *Limited Purpose Coverage Election Form*, are available online after logging in to your account at www.veba.org or upon request by calling the VEBA MEP customer care center at 1-888-828-4953.

What happens if I miss a premium payment?

You must pay the premiums for your PEBB coverage when due. If you pay late or do not pay in full, we will cancel your coverage at the end of the month in which we received the last full premium payment. If your insurance coverage is cancelled, coverage for your dependents also will be cancelled. You cannot enroll again in PEBB coverage unless you regain eligibility.

Medicare Enrollment

What if I’m entitled to Medicare?

When you or your covered dependents become entitled to Medicare, the person entitled to Medicare must enroll and maintain enrollment in Medicare Part A and Part B to remain eligible for PEBB retiree coverage.

Once you or your covered dependents enroll in Medicare Part A and Part B, you must send us a copy of either the Medicare card or a letter from the Social Security Administration that shows the effective date of Medicare Part A and Part B coverage. Mail a photocopy of the Medicare card or letter to:

PEBB Program
Health Care Authority
P.O. Box 42684
Olympia, WA 98504-2684

We will reduce your premium to the lower Medicare rate, if applicable, and notify your health plan of your

Medicare enrollment. If you were paying surcharges in addition to your premium, the surcharge(s) will automatically discontinue when you (the subscriber) enroll in Medicare Part A and Part B.

Entitlement to Medicare also qualifies as a special open enrollment event, allowing you to change your health plans. See “What is a special open enrollment?” on page 16.

Can I enroll in a CDHP and Medicare?

If you are enrolled in a consumer-directed health plan (CDHP) with a health savings account (HSA) when you or your covered dependent(s) become entitled to Medicare Part A and Part B, you must take action as shown in the table below to change your coverage. The PEBB Program must receive your request **no later than 60 days** after the Medicare enrollment date.

| If the person entitled to Medicare Part A and Part B is... | You must: |
|--|--|
| You (the subscriber) | Choose a new medical plan that is not a consumer-directed health plan. |
| Your covered family member | <div>Either:</div> <div><ul style="list-style-type: none">Choose a medical plan that is not a CDHP and keep your Medicare dependent enrolled in PEBB coverage. Your annual deductible and annual out-of-pocket maximum will restart with your new plan.</div> <div>OR</div> <div><ul style="list-style-type: none">Remove your family member from your PEBB coverage before he or she enrolls in Medicare Part A and Part B. The family member will not qualify for COBRA or other continuation coverage through the PEBB Program.</div> |

Making Changes in Coverage

How do I make changes to my account?

To make changes, such as enroll a dependent or elect a different health plan, you must complete and submit the appropriate form(s) during the annual open enrollment or when a special open enrollment event occurs, within PEBB's timelines noted below.

Retiree subscribers may voluntarily remove an eligible dependent from coverage any time during the year. In most cases, the PEBB Program will remove the dependent from coverage prospectively.

Subscribers are required to notify the PEBB Program to remove dependents **no later than 60 days** from the date the dependent no longer meets the eligibility criteria described in WAC 182-12-260. Consequences for not submitting notice within 60 days may include, but are not limited to:

- The dependent may lose eligibility to continue health plan coverage under one of the continuation coverage options described in WAC 182-12-170;
- The subscriber may be billed for claims paid by the health plan for services that were rendered after the dependent lost eligibility; and
- The subscriber may not be able to recover subscriber-paid insurance premiums for dependents who lost eligibility.

What changes can I make during the PEBB annual open enrollment?

To make any of the changes below, the PEBB Program must receive the appropriate form(s) no later than November 30. The enrollment change will become effective January 1 of the following year.

During the annual open enrollment, you can:

- Change your medical and/or dental plan.
- Add an eligible family member to your PEBB coverage. If not enrolled in Medicare Parts A and B you must also:
 - Provide proof of your family member's eligibility with your enrollment form, or they will not be enrolled.
 - Attest to the tobacco use surcharge and spousal coverage surcharge (if applicable to your account.)

- Remove a family member from your PEBB coverage.
- Defer your PEBB medical coverage.
- Enroll in a medical plan if you previously deferred PEBB retiree medical coverage for other coverage.
Note: You cannot enroll during open enrollment if there has been a gap in coverage. (See “Deferring Your Coverage” on page 18).

What is a special open enrollment?

The PEBB Program allows changes outside of the PEBB annual open enrollment when certain events create a special open enrollment. Internal Revenue Code requires the change must be on account of and correspond to the event that affects eligibility for coverage. You must provide proof of the event that created the special open enrollment (for example, a marriage or birth certificate).

To make a change, you must submit the *Retiree Coverage Election/Change* form. The PEBB Program must receive your form **no later than 60 days** after the event that created the special open enrollment. However, if adding a newborn or newly adopted child, and adding the child increases your premium, you must submit this form **no later than 12 months** after the birth or adoption.

In most cases, the change will occur the first day of the month after the date of the event or the date the PEBB Program receives your completed enrollment form, whichever is later. If that day is the first of the month, coverage begins on that date.

Premium surcharge reminder:

When you enroll a dependent as part of a special open enrollment, you must attest on your enrollment form to whether the tobacco use and spousal coverage premium surcharges apply. See the *Premium Surcharge Help Sheet* located in the back of the booklet.

| If this event happens ... | These changes may be allowed: | | |
|---|-------------------------------|---------------------|--------------------|
| | Add dependent | Change medical plan | Change dental plan |
| Marriage or registering a domestic partnership | Yes | Yes | Yes |
| Birth or adoption, including assuming a legal obligation for total or partial support in anticipation of adoption | Yes | Yes | Yes |
| Child becoming eligible as an extended dependent through legal custody or legal guardianship | Yes | Yes | Yes |
| Child becoming eligible as a dependent with a disability | Yes | Yes | Yes |
| Subscriber or dependent losing eligibility for other coverage under a group health plan or through health insurance, as defined by the Health Insurance Portability and Accountability Act (HIPAA) | Yes | Yes | Yes |
| Subscriber or dependent having a change in employment status that affects the subscriber's or dependent's eligibility for the employer contribution toward employer-based group health insurance | Yes | Yes | Yes |
| Subscriber or dependent having a change in enrollment under another employer-based group health insurance during its annual open enrollment that does not align with the PEBB Program's annual open enrollment | Yes | No | No |
| Subscriber's dependent moving from outside the United States to live within the United States | Yes | No | No |
| Subscriber or dependent having a change in residence that affects health plan availability | No | Yes | Yes |
| A court order or National Medical Support Notice requires the subscriber or any other individual to provide insurance coverage for an eligible dependent | Yes | Yes | Yes |
| Subscriber or a subscriber's dependent becoming entitled to coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or losing eligibility for coverage under Medicaid or CHIP | Yes | Yes | Yes |
| Subscriber or a dependent becoming eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP | Yes | Yes | Yes |
| Subscriber or dependent becoming entitled to Medicare or losing eligibility under Medicare; or enrolling (or canceling enrollment) in a Medicare Part D plan | No | Yes | Yes |
| Subscriber's or dependent's current health plan becoming unavailable because the subscriber or dependent is no longer eligible for a health savings account (HSA) | No | Yes | Yes |
| Subscriber or dependent experiencing a disruption of care that could function as a reduction in benefits for the subscriber or his or her dependent for a specific condition or ongoing course of treatment (requires approval by the PEBB Program) | No | Yes | Yes |

Deferring Your Coverage

Deferral rights for retirees

If you choose not to enroll at retirement or separation from state service, you may defer (postpone or interrupt) your enrollment in PEBB retiree medical and dental coverage at or after retirement if continuously enrolled in other medical coverage as described below. If you defer enrollment in a PEBB retiree medical plan, you may not enroll in a PEBB dental plan during your deferral period. Except as stated below, if you defer enrollment in a PEBB retiree medical plan, you also defer enrollment for your dependents.

- If you are continuously enrolled in a PEBB, Washington State school district or educational service district-sponsored medical plan as a dependent.
- Beginning January 1, 2001, if you are continuously enrolled in employer-based group medical insurance, including such coverage included under COBRA, as an employee or the dependent of an employee. This does not include an employer's retiree coverage.
- Beginning January 1, 2001, if you are continuously enrolled in medical coverage as a retiree or a dependent of a retiree in TRICARE or the Federal Employees Health Benefits Program. You will have a one-time opportunity to enroll or reenroll in a PEBB health plan.
- Beginning January 1, 2006, if you are continuously enrolled in Medicare Part A and Part B and a Medicaid program that provides creditable coverage. To be considered creditable coverage, your Medicaid coverage must include coverage for medical and hospital benefits. Your eligible dependents who are not eligible for creditable coverage under Medicaid may continue PEBB coverage.
- Beginning January 1, 2014, if you are not eligible for Medicare Part A and Part B you may defer PEBB retiree coverage if enrolled in qualified health plan coverage through a health benefits exchange established under the Affordable Care Act. This does not include Medicaid coverage, also known as Apple Health in Washington State. You will have a one-time opportunity to enroll or reenroll in a PEBB health plan.

To defer enrollment in a PEBB health plan, retiring employees or enrolled retiree subscribers must submit a *Retiree Coverage Election/Change* form (form A) to the PEBB Program requesting to defer.

- **If you are a retiring or separating employee** the PEBB Program must receive the form **no later than 60 days** after your employer-paid or COBRA coverage ends. The PEBB Program will defer your enrollment the first of the month following the date your employer-paid or COBRA coverage ends.
- **If you are a retiree enrolled in PEBB retiree insurance coverage**, the PEBB Program must receive your election/change form before you defer coverage. Enrollment will be deferred effective the first of the month following the date the PEBB Program receives your form.

Deferring retiree life insurance

If you have deferred your PEBB retiree health coverage and become eligible for the employer contribution toward PEBB life insurance (for example, by returning to state service), you may keep or cancel your retiree term life insurance. To do either, complete the *Life and AD&D Insurance Enrollment/Change Form* and submit it to your employer's personnel, payroll, or benefits office. If you cancel your retiree term life insurance, you must complete the *Retiree Coverage Election/Change* form to reenroll in PEBB retiree term life insurance when you are no longer eligible for PEBB employer-sponsored benefits. The PEBB Program must receive this form **no later than 60 days** after your employer-paid coverage ends.

Deferral rights for survivors of employees or retirees

A surviving spouse, registered domestic partner, or child of an employee, retiree, or Washington State school district or educational service district employee who is eligible for PEBB retiree coverage under WAC 182-12-265 must defer enrollment under one of the circumstances listed below. If a survivor defers enrollment in PEBB retiree insurance coverage, he or she may not enroll in a PEBB dental plan.

- If a survivor is continuously enrolled in a PEBB, Washington State school district, or educational service district-sponsored medical plan as a dependent.
- Beginning January 1, 2001, if a survivor is continuously enrolled in employer-based group medical insurance, including such coverage continued under COBRA, as an employee or the dependent of an employee.
- Beginning January 1, 2001, if a survivor is continuously enrolled in medical coverage as a retiree or the dependent of a retiree in TRICARE or the Federal Employees Health Benefits Program. These survivors will have a one-time opportunity to enroll or reenroll in a PEBB health plan.
- Beginning January 1, 2006, if a survivor is continuously enrolled in Medicare Part A and Part B and a Medicaid program that provides creditable coverage. To be considered creditable coverage, the survivor's Medicaid coverage must include coverage for medical and hospital benefits. A survivor's eligible dependent(s) who are not eligible for creditable coverage under Medicaid may continue PEBB retiree coverage.
- Survivors who are not eligible for Medicare Part A and Part B may defer PEBB retiree insurance coverage if enrolled in qualified health plan coverage offered through any health benefits exchange established under the Affordable Care Act. This does not include Medicaid coverage, also known as Apple Health in Washington State. These survivors will have a one-time opportunity to enroll or reenroll in a PEBB health plan.

Required timelines to defer

To defer enrollment in PEBB retiree insurance coverage, a survivor must submit a *Retiree Coverage Election/Change* form (form A) to the PEBB Program:

- In the event of an employee or retiree's death, the PEBB Program must receive the form **no later than 60 days** after the death. Enrollment will be deferred effective the first of the month following the date of the death.

- If a survivor enrolls in PEBB retiree insurance coverage and is eligible to defer coverage in the future, the PEBB Program must receive the form before the survivor defers coverage. Enrollment will be deferred effective the first of the month after the PEBB Program receives the form.

Deferral rights for survivors of emergency services personnel

A surviving spouse, state-registered domestic partner, or dependent child of emergency services personnel killed in the line of duty who is eligible for PEBB retiree insurance coverage under WAC 182-12-250 may defer enrollment under the circumstances listed below. If a survivor defers enrollment in PEBB retiree insurance coverage, he or she may not enroll in a PEBB dental plan.

- If a survivor is continuously enrolled in a PEBB, Washington State school district, or educational service district-sponsored medical plan as a dependent.
- Beginning January 1, 2001, if a survivor is continuously enrolled in employer-based group medical insurance, including such coverage continued under COBRA, as an employee or the dependent of an employee.
- Beginning January 1, 2001, if a survivor is continuously enrolled in medical coverage as a retiree or the dependent of a retiree in TRICARE or the Federal Employees Health Benefits Program. These survivors will have a one-time opportunity to enroll or reenroll in a PEBB health plan.
- Beginning January 1, 2006, if a surviving dependent is continuously enrolled in Medicare Part A and Part B and a Medicaid program that provides creditable coverage. To be considered creditable coverage, the surviving dependent's Medicaid coverage must include coverage for medical and hospital benefits. A survivor's eligible dependent(s) who are not eligible for creditable coverage under Medicaid may continue PEBB coverage.

(continued)

Deferring Your Coverage

- Survivors who are not eligible for Medicare Part A and Part B may defer PEBB retiree insurance coverage if enrolled in qualified health plan coverage offered through any health benefits exchange established under the Affordable Care Act. This does not include Medicaid coverage, also known as Apple Health in Washington State. These survivors will have a one-time opportunity to enroll or reenroll in a PEBB health plan.

To defer enrollment in PEBB retiree insurance, a survivor must submit a *Retiree Coverage Election/Change* form to the PEBB Program. The form must be received by the PEBB Program **no later than 180 days** after the later of:

- The death of the emergency service employee.
- The date on the eligibility letter from the Washington State Department of Retirement Systems or the board for volunteer firefighters and reserve officers.
- The last day the survivor was covered under a health plan through the emergency service employee's employer.
- The last day the survivor was covered under COBRA coverage from the emergency service employee's employer as described in WAC 182-12-250.

How do I enroll after deferring PEBB coverage?

If a retiree or survivor deferred enrollment in PEBB retiree coverage, he or she may enroll under the following circumstances, as long as he or she has had continuous enrollment in qualifying coverage as required.

- **During any PEBB annual open enrollment.** The PEBB Program must receive the *Retiree Coverage Election/Change* form and proof of continuous enrollment in other qualified health plan coverage no later than the last day of the PEBB Program's open enrollment period. You cannot enroll during open enrollment if there has been a gap in coverage. To return from deferral during open enrollment, your other coverage must be continuous through December 31.

- **When other qualified coverage ends.** The PEBB Program must receive the *Retiree Coverage Election/Change* form **no later than 60 days** after the date other qualifying coverage ends. Enrollment will begin the first day of the month after other qualifying coverage ends.

Although a retiree or survivor has 60 days to enroll, he or she must pay PEBB premiums and any applicable surcharges back to when other qualifying coverage ended.

Proof of continuous enrollment in other qualifying medical coverage must list when the coverage began and ended.

A retiree or survivor has a one-time opportunity to enroll in PEBB medical and dental coverage if he or she deferred enrollment in PEBB coverage for TRICARE, the Federal Employees Health Benefits Program, or coverage through a health benefits exchange established under the Affordable Care Act.

How do I enroll after deferring PEBB coverage for Medicaid?

Retirees or survivors who defer PEBB retiree coverage while continually enrolled in Medicare Part A and Part B and a Medicaid program that provides creditable coverage may enroll in PEBB coverage if they lose their Medicaid coverage. The PEBB Program must receive the *Retiree Coverage Election/Change* form **no later than 60 days** after the date Medicaid coverage ends, or no later than the end of the calendar year when the retiree or survivor's Medicaid coverage ends, if he or she was also eligible under subsidized Medicare Part D.

Retirees or survivors who defer enrollment may enroll in a PEBB health plan if he or she receives formal notice that the Health Care Authority has determined it is more cost-effective to enroll the retiree or survivor (or his or her eligible dependent) in PEBB medical than a medical assistance program.

When PEBB Coverage Ends

How do I cancel coverage?

To cancel your PEBB retiree coverage, you must submit your request in writing to:

PEBB Program
Health Care Authority
P.O. Box 42684
Olympia, WA 98504-2684

In most cases, plan enrollment will end at the end of the month the PEBB Program receives your written request.

If you are enrolled in a Medicare Advantage plan, you must also send the PEBB Program a completed PEBB *Medicare Advantage Plan Disenrollment Form* (form D). We will send form D to your plan, which will remove you from coverage on the first of the month after the plan receives the form.

If you cancel your PEBB retiree coverage, you cannot enroll again later unless you regain eligibility for PEBB coverage, for example, by returning to employment in a PEBB, Washington State school district or educational service district benefits-eligible position.

When does PEBB coverage end?

PEBB insurance covers an entire month and must end as follows:

- When you or a dependent loses eligibility for PEBB benefits, coverage ends on the last day of the month in which eligibility ends.
- Coverage for you and your enrolled dependents ends on the last day of the month that you last paid the full premium. The PEBB Program charges a full month's premium for each calendar month of coverage. The HCA will not prorate a premium if an enrollee dies or cancels his or her coverage before the end of the month.

What are my options when coverage ends?

You, your dependents, or both may temporarily continue your PEBB coverage by self-paying the premiums after your eligibility ends. Options for continuing coverage vary, based on the reason you lost eligibility.

The PEBB Program will mail a *PEBB Continuation of Coverage Election Notice* booklet to you or your dependents when retiree coverage ends. You or your eligible dependents must apply to the PEBB Program to continue coverage. The PEBB Program must receive the election form **no later than 60 days** after the mailing date on the *PEBB Continuation of Coverage Election Notice* booklet, or you will lose all rights to continue PEBB coverage.

Your dependents lose eligibility when you die; however, they may enroll in or continue PEBB retiree coverage even if they were not covered at the time of your death. Your spouse or registered domestic partner may continue coverage indefinitely as long as he or she pays the premiums and any applicable premium surcharges in full and on time. Your other dependents may continue coverage until they are no longer eligible under PEBB rules.

If your spouse is no longer eligible due to divorce, he or she may continue coverage for up to 36 months under COBRA.

If your registered domestic partnership ends, PEBB will offer your former domestic partner and his or her children an extension of coverage for up to 36 months.

If your dependent child is no longer eligible under PEBB rules, he or she may continue under COBRA for up to 36 months.

For information about your rights and obligations under PEBB rules and federal law, review the *PEBB Continuation of Coverage Election Notice* booklet.

Selecting a PEBB Medical Plan

How can I compare the plans?

All medical plans, except for Premera Blue Cross Medicare Supplement Plan F, cover the same basic health care services but vary in other ways, such as provider networks, premiums, and drug formularies. For example, the consumer-directed health plans (CDHPs) have the lowest monthly premiums, but they also have higher annual deductibles and higher out-of-pocket maximums.

Group Health and Kaiser Permanente are managed-care plans, while the Uniform Medical Plan (UMP) is a preferred-provider organization (PPO).

A managed-care plan requires you to select a primary care provider (PCP) within its network to fulfill or coordinate all of your health needs. The plan may not pay benefits if you see a non-contracted provider. A PPO is a health plan that allows you to self-refer to any approved provider type in most cases, but usually provides a higher reimbursement if the provider contracts with the plan.

Remember, if you cover eligible dependents, everyone must enroll in the same medical and dental plans. To choose a plan that best meets your needs, here are some things to consider:

Cost. Premiums vary by plan. A higher premium doesn't necessarily mean higher quality of care or better benefits; each plan has the same basic level of benefits (except Medicare Supplement Plan F).

Your costs also include:

Deductible. All medical plans, except Group Health's and Kaiser Permanente's Medicare Advantage plans, require you to pay an annual deductible before the plan pays for covered services. UMP Classic also has a separate annual deductible for some prescription drugs. Preventive care and certain other services are exempt from the medical plans' deductibles. This means you do not have to pay your deductible before the plan covers the service.

Coinsurance or copays. PEBB's managed-care plans require you to pay a fixed amount (called a copay) or percentage of an allowed fee (called a coinsurance)

when you receive network care. UMP Classic and the CDHPs require members to pay coinsurance.

Out-of-pocket limit. The annual out-of-pocket limit is the most you pay in a calendar year. UMP Classic has a separate out-of-pocket limit for prescription drugs.

Once you have paid this amount, the plans pay 100 percent of allowed charges for most covered benefits for the rest of the calendar year. Certain charges you incur during the year, such as your annual deductible, copays, and coinsurance, count toward your out-of-pocket limit. However, here are a few costs that do not apply toward your annual out-of-pocket limit:

- Monthly premiums and applicable surcharges
- Charges above what the plan pays for a benefit
- Charges above the plan's allowed amount paid to a provider
- Charges for services or treatments the plan doesn't cover
- Coinsurance for non-network providers
- Prescription-drug deductible and prescription-drug coinsurance (UMP Classic only)

Eligibility. You must be enrolled in Medicare Part A and Part B to enroll in the Medicare Advantage or Medicare Supplement plans. Also, not everyone qualifies to enroll in a CDHP with a health savings account (HSA). See "What do I need to know about the consumer-directed health plans?" on page 24.

Geography. In most cases, you must live in the plan's service area to join the plan. See "Medical Plans Available by County" on page 27. Be sure to contact the plan(s) you're interested in to ask about provider availability in your county.

Referral procedures. Some plans allow you to self-refer to any network provider; others require you to have a referral from your primary care provider. All plans allow self-referral to a participating provider for women's health-care services.

Your provider. If you have a long-term relationship with your doctor or health-care provider, you should verify whether he or she is in the plan's network.

Contact the provider or plan before you join. Your family members may choose the same provider, but it's not required. Each family member may select from any available provider in the plan's network.

After you join a plan, you may change your provider, although the rules vary by plan.

Paperwork. In general, PEBB plans don't require you to file claims. However, UMP Classic members may need to file a claim if they receive services from a non-network provider. CDHP members should also keep paperwork received from their provider or from qualified health care expenses to verify eligible payments or reimbursements from their health savings account.

Coordination with your other benefits. If you are also covered through your spouse's or registered domestic partner's comprehensive group health coverage, call the medical and/or dental plan(s) directly to ask how they will coordinate benefits.

All PEBB plans (except Premera Blue Cross Medicare Supplement Plan F) coordinate benefit payments with other group plans, Medicaid, and Medicare. This is called coordination of benefits (COB). This coordination ensures benefit costs are more fairly distributed when a person is covered by more than one plan. However, the amount your PEBB plan pays for benefits will not change for a particular service or treatment, even if you or a dependent have an individual medical or dental policy covering that service or treatment.

Exception: PEBB plans that cover prescription drugs will not coordinate prescription-drug coverage with Medicare Part D. All PEBB plans cover prescription drugs except Premera Blue Cross Medicare Supplement Plan F. If you enroll in Medicare Part D, you must enroll in Premera Blue Cross Medicare Supplement Plan F or lose your PEBB retiree coverage.

You can compare some of the medical plans' benefits in this booklet on pages 29-38 and at www.hca.wa.gov/pebb.

What type of plan should I select?

PEBB retirees may choose a managed-care plan, Medicare supplement plan, Medicare Advantage plan, consumer-directed health plan, or a preferred-provider plan. Your options are based on which plans are available in your county and whether you are enrolled in Medicare Part A and Part B.

Medicare options:

- Group Health Medicare Plan (Medicare Advantage [Clear Care] or Original Medicare coordination plan)
- Kaiser Permanente Senior Advantage
- Medicare Supplement Plan F, administered by Premera Blue Cross
- UMP Classic (Medicare), administered by Regence BlueShield

Non-Medicare options:

Managed-care plans

- Group Health Classic
- Group Health Value
- Kaiser Permanente Classic

Consumer-directed health plans (CDHPs)

- Group Health CDHP
- Kaiser Permanente CDHP
- UMP CDHP, administered by Regence BlueShield

Preferred-provider plan

- UMP Classic, administered by Regence BlueShield

Generally, a classic plan has a higher premium than a value plan, but the classic plan's annual deductible, copays, or coinsurance are lower.

A CDHP lets you use a health savings account (HSA) to help pay for out-of-pocket medical expenses tax-free. A CDHP has a lower monthly premium than most plans, with a higher deductible and a higher out-of-pocket limit. Your medical deductible and your medical coinsurances and copays count toward your out-of-pocket limit.

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Selecting a PEBB Medical Plan

What do I need to know about the consumer-directed health plans?

You cannot enroll in a CDHP with a health savings account (HSA) if:

- You or your spouse or registered domestic partner is enrolled in Medicare or Medicaid.
- You are enrolled in another comprehensive medical plan — for example, on a spouse's or domestic partner's plan.
- You or your spouse or registered domestic partner is enrolled in a Voluntary Employee Beneficiary Association (VEBA) trust account, unless you convert it to a limited VEBA.
- You have received Veterans' Administration benefits (including prescription drugs) in the three months before you enroll in a CDHP/HSA, or have TRICARE coverage.
- You enrolled in a flexible spending arrangement (FSA) or a health reimbursement arrangement (HRA). This also applies if your spouse has an FSA, even if you are not covering your spouse on your CDHP. This does not apply if the FSA or HRA is a limited purpose account, or for a post-deductible FSA.
- You are claimed as a dependent on someone else's tax return.

When you enroll in a CDHP, you are automatically enrolled in a tax-free HSA that you can use to pay for IRS-qualified out-of-pocket medical expenses (such as deductibles, copays, and coinsurance), including some expenses and services that your health plans may not cover. See *IRS Publication 969 Health Savings Accounts and Other Tax Favored Health Plans* for details.

The HSA is set up by your health plan with HealthEquity, Inc., to pay for or reimburse your costs for qualified medical expenses.

The PEBB Program contributes the following amounts to your HSA:

- \$58.34 each month for an individual subscriber, up to \$700.08 for the 2015 calendar year; or
- \$116.67 each month for a subscriber with one or

more enrolled family members, up to \$1,400.04 for the 2015 calendar year.

- \$125 if you qualified for a wellness incentive in 2014.

The contributions from the PEBB Program go into the HSA in monthly installments over the year, and are deposited on the last day of each month. The entire annual amount is not deposited in your HSA on January 1.

You can also choose to contribute to your HSA through direct deposits to HealthEquity, and you may be able to deduct your HSA contributions from your federal income taxes. In 2015, the annual HSA contribution limit is \$3,350 (individuals) and \$6,650 (you and one or more family members). If you are age 55 or older, you may contribute up to \$1,000 more annually in addition to these limits. To ensure you do not go beyond the maximum allowable limit, make sure to calculate **both** the PEBB Program's contribution amount(s) for the year, the SmartHealth incentive in January (if eligible), and any amount you contribute.

Some other features of the CDHP/HSA:

- If you cover one or more family members, you must pay the entire family deductible before the CDHP begins paying benefits.
- Your prescription-drug costs count toward the annual deductible and out-of-pocket maximum if you enroll in the Group Health CDHP or Kaiser Permanente CDHP.
- Your HSA balance can grow over the years, earn interest, and build savings that you can use to pay for health care as needed and/or pay for Medicare Part B premiums.

What happens to my health savings account when I leave the CDHP?

If you choose a medical plan that is not a CDHP you should know:

- You won't forfeit any unspent funds in your HSA after enrolling in a different plan. You can spend your HSA funds on qualified medical expenses in the future. However, you and the PEBB Program can no longer contribute to your HSA.
- HealthEquity will charge you a monthly fee if you

have less than \$2,500 in your HSA after December 31. You can avoid this charge by either ensuring you have at least \$2,500 in your HSA or by spending all of your HSA funds by December 31. Other fees may apply. Contact HealthEquity for details.

- You must contact HealthEquity to stop automatic direct deposits to your HSA if you previously set this up.

Medicare reminder:

If you enroll in a CDHP and you or a covered family member become eligible for Medicare Part A or Part B during the year, you must change to another PEBB medical plan that is not a CDHP, or remove the Medicare-eligible family member from your PEBB coverage. If you change your medical plan midyear, any payments you have made toward your annual deductible and out-of-pocket maximum will not apply to your new plan. See “Can I enroll in a CDHP and Medicare?” on page 15.

What do I need to know about the Medicare Advantage and Medicare Supplement plans?

Medicare Advantage plans are available from Group Health and Kaiser Permanente, but are not available in every county (see page 27). If you are enrolled in Medicare Part A and Part B and you choose Group Health or Kaiser Permanente, you must enroll in the Medicare Advantage plan if they offer it in your county.

These plans contract with Medicare to provide all Medicare-covered benefits; however, most also cover the deductibles, coinsurance, and additional benefits not covered by Medicare. Neither the health plan nor Medicare will pay for services received outside of the plan's network except for authorized referrals and emergency care.

Group Health also offers an Original Medicare plan for Medicare retirees who live in a county not served by the Group Health Medicare Advantage plan (called Clear Care).

Medicare Supplement Plan F, administered by Premiera Blue Cross, allows the use of any Medicare-contracted physician or hospital nationwide. The plan is designed to supplement your Medicare coverage by

reducing your out-of-pocket expenses and providing additional benefits. It pays some Medicare deductibles and coinsurances, but primarily supplements only those services covered by Medicare.

The PEBB Program does not offer the high-deductible Plan F shown in the *Outline of Medicare Supplement Coverage* that begins on page 35.

In Medicare Supplement Plan F, benefits such as vision, hearing exams, and routine physical exams may have limited coverage or may not be covered at all.

If you select Medicare Supplement Plan F, any eligible family members who are not entitled to Medicare will be enrolled in UMP Classic.

How do PEBB plans with prescription-drug coverage compare to Medicare Part D?

All PEBB medical plans, except Premiera Blue Cross Medicare Supplement Plan F, have prescription-drug coverage that is “creditable coverage.” That means it is as good or better than the standard Medicare prescription-drug coverage (Medicare Part D). So:

- Your plan, on average for all plan members, meets at least what the standard Medicare prescription-drug coverage will pay.
- You can keep your PEBB coverage and not pay a late enrollment penalty if you decide to enroll in Medicare prescription-drug coverage later.
- You can enroll in a Medicare Part D plan when you first become entitled to Medicare, during the Medicare Part D open enrollment, and after you lose creditable prescription-drug coverage through your current plan. Open enrollment for Medicare Part D occurs toward the end of the year. However, joining Medicare Part D may affect your enrollment in the PEBB Program.

The PEBB Program does not offer Medicare Part D. You do not have to enroll in Medicare Part D. If you do enroll in Medicare Part D, the only PEBB medical plan that allows enrollment with Medicare Part D is Premiera Blue Cross Medicare Supplement Plan F. If you are enrolled in any other PEBB medical plan, you cannot enroll in Medicare Part D and keep your PEBB coverage.

How to Find the Summaries of Benefits and Coverage

The Affordable Care Act requires the PEBB Program and health plans to provide a standardized comparison tool of medical plan benefits, terms, and conditions. This tool, called the Summary of Benefits and Coverage (or SBC), allows plan applicants and members to compare things like:

- What is not included in the plan's out-of-pocket limit?
- Do I need a referral to see a specialist?
- Are there services this plan doesn't cover?

The PEBB Program and/or medical plans must provide an SBC (or explain how to get one) at different times throughout the year, such as when someone applies for coverage, upon plan renewal, and when requested. The SBC is available from your health plan in Spanish, Tagalog, Chinese, and Navajo.

| If you want to request an SBC from your current PEBB medical plan | If you want to request an SBC from another PEBB medical plan |
|---|---|
| <p>You can either:</p> <ul style="list-style-type: none">• Go to your plan's website to view it online; OR• Call your plan to request a paper copy at no charge. | <p>You can either:</p> <ul style="list-style-type: none">• Go to the plan's website to view it online; OR• Call the PEBB Program at 1-800-200-1004 to request a paper copy at no charge. |

You can find the medical plans' websites and customer service phone numbers on page 2.

2015 Medical Plans Available by County

In most cases, you must live in the medical plan's service area to join the plan. Be sure to call the plan(s) you are interested in to ask about provider availability in your county.

| Washington | | | |
|--|---|--|---|
| Group Health Classic Group Health consumer-directed health plan (CDHP) Group Health Value <i>These plans not available to Medicare members</i> | <ul style="list-style-type: none"> Benton Columbia Franklin Grays Harbor (ZIP Codes 98541, 98557, 98559, and 98568) Island King Kitsap Kittitas | <ul style="list-style-type: none"> Lewis Lincoln (ZIP Codes 99008, 99029, 99032, and 99122) Mason Pend Oreille (ZIP Codes 99009 and 99180) Pierce San Juan Skagit | <ul style="list-style-type: none"> Snohomish Spokane Stevens (ZIP Codes 99006, 99013, 99026, 99034, 99040, 99110, 99148, and 99173) Thurston Walla Walla Whatcom Whitman Yakima |
| Group Health Medicare Advantage | <ul style="list-style-type: none"> Grays Harbor (ZIP Codes 98541, 98557, 98559, and 98568) Island King Kitsap | <ul style="list-style-type: none"> Lewis Mason (ZIP Codes 98312, 98524, 98528, 98541, 98546, 98548, 98555, 98560, 98584, 98588, and 98592) Pierce | <ul style="list-style-type: none"> San Juan Skagit Snohomish Spokane Thurston Whatcom |
| Group Health Original Medicare | <ul style="list-style-type: none"> Benton Columbia Franklin Kittitas Lincoln (ZIP Codes 99008, 99029, 99032, and 99122) | <ul style="list-style-type: none"> Mason* Pend Oreille (ZIP Codes 99009 and 99180) Stevens (ZIP Codes 99006, 99013, 99026, 99034, 99040, 99110, 99148, and 99173) | <ul style="list-style-type: none"> Walla Walla Whitman Yakima <p>* Original Medicare is available in ZIP Codes where Medicare Advantage is not available.</p> |
| Kaiser Permanente Classic Kaiser Permanente consumer-directed health plan (CDHP) <i>These plans not available to Medicare members</i> | <ul style="list-style-type: none"> Clark Cowlitz Lewis (ZIP Codes 98591, 98593, and 98596) | <ul style="list-style-type: none"> Skamania (ZIP Codes 98639, 98648, and 98671) Wahkiakum (ZIP Codes 98612 and 98647) | |
| Kaiser Permanente Senior Advantage | <ul style="list-style-type: none"> Clark Cowlitz | <ul style="list-style-type: none"> Lewis (ZIP Codes 98591, 98593, and 98596) Skamania | <ul style="list-style-type: none"> Wahkiakum (ZIP Codes 98612 and 98647) |
| Medicare Supplement Plan F, administered by Premiera Blue Cross | Available in Washington counties and nationwide. | | |
| UMP Classic UMP consumer-directed health plan UMP Medicare | Available in all Washington counties and worldwide. | | |

(continued)

Oregon

| | |
|---|---|
| Group Health Classic Group Health consumer-directed health plan (CDHP) Group Health Original Medicare Group Health Value | <ul style="list-style-type: none"> • Umatilla (ZIP Codes 97810, 97813, 97835, 97862, 97882, and 97886) |
| Kaiser Permanente Classic Kaiser Permanente consumer-directed health plan (CDHP) <i>These plans not available to Medicare members</i> | <ul style="list-style-type: none"> • Benton (ZIP Codes 97330, 97331, 97333, 97339, and 97370) • Clackamas (ZIP Codes 97004, 97009, 97011, 97013, 97015, 97017, 97022, 97023, 97027, 97034-36, 97038, 97042, 97045, 97049, 97055, 97067, 97068, 97070, 97086, 97089, 97222, and 97267-69) • Columbia • Hood River (ZIP Code 97014) • Linn (ZIP Codes 97321-22, 97335, 97348, 97355, 97358, 97360, 97374, 97377, and 97389) • Marion (ZIP Codes 97002, 97020, 97026, 97032, 97071, 97137, 97301-3, 97305-12, 97314, 97317, 97325, 97342, 97346, 97352, 97362, 97373, 97375, 97381, 97383-85, and 97392) • Multnomah • Polk • Washington • Yamhill |
| Kaiser Permanente Senior Advantage | <ul style="list-style-type: none"> • Benton (ZIP Codes 97330, 97331, 97333, 97339, and 97370) • Clackamas • Columbia • Hood River • Linn (ZIP Codes 97321-22, 97335, 97355, 97358, 97360, 97374, and 97389) • Marion • Multnomah • Polk • Washington • Yamhill |
| Medicare Supplement Plan F, administered by Premiera Blue Cross | Available in Oregon counties and nationwide. |
| UMP Classic UMP consumer-directed health plan UMP Medicare | Available in all Oregon counties and worldwide. |

Idaho

| | |
|---|---|
| Group Health Classic Group Health consumer-directed health plan (CDHP) Group Health Original Medicare Group Health Value | <ul style="list-style-type: none"> • Kootenai • Latah |
| Medicare Supplement Plan F, administered by Premiera Blue Cross | Available in Idaho counties and nationwide. |
| UMP Classic UMP consumer-directed health plan UMP Medicare | Available in all Idaho counties and worldwide. |

2015 Medical Benefits Cost Comparison

The chart below briefly compares the per-visit costs of some in-network benefits for PEBB plans, and extended-network benefits for Group Health's consumer-directed health plan (CDHP). Some copays and coinsurance do not apply until after you have paid your annual deductible. Call the plans directly for more information on specific benefits, including preauthorization requirements and exclusions.

| Annual Costs | Group Health | | | | Kaiser Permanente | | Uniform Medical Plan ³ | |
|---|--|--------------------------------|--|------------------------------------|---|------------------------------------|--|--|
| | Classic | Value | CDHP | CDHP Extended Network ² | Classic | CDHP | Classic | CDHP |
| | You pay | | | | You pay | | You pay | |
| Medical deductible Applies to out-of-pocket limit | \$250/person \$750/family | \$350/person \$1,050/family | \$1,400/person \$2,800/family* | | \$250/person \$750/family | \$1,400/person \$2,800/family* | \$250/person \$750/family | \$1,400/person \$2,800/family* |
| Medical out-of-pocket limit¹ (See separate prescription drug out-of-pocket limit for UMP Classic.) | \$2,000/person \$4,000/family | | \$5,100/person \$10,200/family** | | \$2,000/person \$4,000/family | \$4,200/person \$8,400/family** | \$2,000/person \$4,000/family | \$4,200/person \$8,400/family** |
| | Your deductible, copays, and coinsurance for all covered services apply. | | | | Your deductible, copays, and coinsurance for most covered services apply. | | Your medical deductible, copays, and coinsurance for most covered medical services apply. | Your deductible and coinsurance for most covered services apply. |
| Prescription drug deductible | None | | Prescription drug costs apply toward medical deductible. | | Prescription drug costs apply toward medical deductible. | | \$100/person \$300/family* (Tier 2 and 3 drugs only) | Prescription drug costs apply toward medical deductible. |
| Prescription drug out-of-pocket limit¹ | Prescription drug copays and coinsurance apply to the medical out-of-pocket limit. | | | | Prescription drug copays apply to the medical out-of-pocket limit. | | \$2,000/person Your prescription drug deductible, copays, and coinsurance for all covered prescription drugs apply. | Prescription coinsurance applies to the medical out-of-pocket limit. |

* Must meet family medical or prescription drug deductible before plan pays benefits.

** Must meet family medical out-of-pocket limit before plan pays 100% for covered benefits.

¹ Premiums, charges for services in excess of a benefit, charges in excess of the plan's allowed amount, coinsurance for out-of-network providers (UMP), and charges for non-covered services do not apply to out-of-pocket limit³. Non-covered services include, but

are not limited to, member costs above the vision and hearing aid hardware maximums.

² Group Health's CDHP Extended Network includes First Choice Health Network, First Health Network, and its affiliated providers, and any other licensed provider in the U.S.

³ UMP members who see an out-of-network provider will pay 40% coinsurance of the plan's allowed amount for most services plus any amount the provider charges over the allowed amount.

| Benefits | Group Health | | | | Kaiser Permanente | | Uniform Medical Plan ³ | |
|--|---|--|------|--|-------------------|------|---|------|
| | Classic | Value | CDHP | CDHP Extended Network ² | Classic | CDHP | Classic | CDHP |
| | You pay | | | | You pay | | You pay | |
| Ambulance Air or ground, per trip | 20% | 20% | 10% | 30% | 15% | 15% | 20% | 20% |
| Diagnostic tests, laboratory, and x-rays | \$0; MRI/ CT/PET scan \$30 | \$0; MRI/ CT/PET scan \$40 | 10% | 30% | \$10 | 15% | 15% | 15% |
| Durable medical equipment, supplies, and prosthetics | 20% | 20% | 10% | 30% | 20% | 20% | 15% | 15% |
| Emergency room (copay waived if admitted) | \$250 | \$300 | 10% | 10% | \$75 | 15% | \$75 copay + 15% | 15% |
| Hearing Routine annual exam | \$15 | \$20 | 10% | 30% | \$30 | \$30 | \$0 | 15% |
| Hardware | You pay any amount over \$800 every 36 months after deductible has been met for hearing aid and rental/repair combined. | | | | | | | |
| Home health | \$0 | \$0 | 10% | 30% | 15% | 15% | 15% | 15% |
| Hospital services Inpatient | \$150/day up to \$750 maximum/ admission | \$200/day up to \$1,000 maximum/ admission | 10% | 30% | 15% | 15% | \$200/day up to \$600 maximum/ year per person + 15% professional fees | 15% |
| Outpatient | \$150 | \$200 | 10% | 30% | 15% | 15% | 15% | 15% |
| Office visit Primary care | \$15 | \$20 | 10% | 30% | \$20 | \$20 | 15% | 15% |
| Urgent care | \$15 | \$20 | 10% | 30% | \$40 | \$40 | 15% | 15% |
| Specialist | \$30 | \$40 | 10% | 30% | \$30 | \$30 | 15% | 15% |
| Mental health | \$15 | \$20 | 10% | 30% | \$20 | \$20 | 15% | 15% |
| Chemotherapy | \$15 | \$20 | 10% | 30% | \$0 | \$0 | 15% | 15% |
| Radiation | \$30 | \$40 | 10% | 30% | \$0 | \$0 | 15% | 15% |
| Physical, occupational, and speech therapy (per-visit cost for 60 visits/year combined) | \$15 | \$20 | 10% | 30% | \$30 | \$30 | 15% | 15% |

| Benefits | Group Health | | | | Kaiser Permanente | | Uniform Medical Plan ³ | |
|--|---|-----------------|-----------------|--|-------------------|----------------|---|------|
| | Classic | Value | CDHP | CDHP Extended Network ² | Classic | CDHP | Classic | CDHP |
| | You pay | | | | You pay | | You pay | |
| Prescription drugs Retail pharmacy (up to a 30-day supply) | | | | | | | | |
| Value tier | \$5 | \$5 | \$5 | \$5 | Does not apply | Does not apply | 5% (up to \$10/30-day supply) | |
| Tier 1 | \$20 | \$20 | \$20 | \$20 | \$15 | \$15 | 10% (up to \$25/30-day supply) | |
| Tier 2 | \$40 | \$40 | \$40 | \$40 | \$30 | \$30 | 30% (up to \$75/30-day supply) | 15% |
| Tier 3 | 50% up to \$250 | 50% up to \$250 | 50% up to \$250 | 50% up to \$250 | Does not apply | Does not apply | 50% (up to \$150 for specialty drugs; there is no per-prescription cost-limit for non-specialty Tier 3 drugs) | |
| Mail order (up to a 90-day supply) | | | | | | | | |
| Value tier | \$10 | \$10 | \$10 | Does not apply | Does not apply | Does not apply | 5% (up to \$30/90-day supply) | |
| Tier 1 | \$40 | \$40 | \$40 | Does not apply | \$30 | \$30 | 10% (up to \$75/90-day supply) | |
| Tier 2 | \$80 | \$80 | \$80 | Does not apply | \$60 | \$60 | 30% (up to \$225/90-day supply) | 15% |
| Tier 3 | 50% up to \$750 | 50% up to \$750 | 50% up to \$750 | Does not apply | Does not apply | Does not apply | 50% (up to \$150 for specialty drugs; there is no per-prescription cost-limit for non-specialty Tier 3 drugs) | |
| Preventive care | \$0 | \$0 | \$0 | Not covered ⁴ | \$0 | \$0 | \$0 | \$0 |
| | See certificate of coverage or check with plan for full list of services. | | | | | | | |
| Spinal manipulations | \$15 | \$20 | 10% | 30% | \$30 | \$30 | 15% | 15% |
| Vision care⁵ Exam (annual) | \$15 | \$20 | 10% | 30% | \$20 | \$20 | \$0 | \$0 |
| Glasses and contact lenses | You pay any amount over \$150 every 24 months (or two calendar years for UMP) for frames, lenses, contacts, and fitting fees combined. Exception: For UMP Classic, you pay any amount over \$65 for contact lens fitting fees. | | | | | | | |

⁴ Preventive care is not covered in Group Health's CDHP Extended Network except for routine mammography screening. Annual medical deductible and 30% coinsurance applies.

⁵ Contact your plan about costs for children's vision care.

2015 Medicare Benefits Comparison

The chart below briefly compares the per-visit costs of some in-network benefits for PEBB plans. Some copays and coinsurance do not apply until after you have paid your annual deductible. Call the plans directly for more information on specific benefits, including preauthorization requirements and exclusions. Group Health and Kaiser Permanente offer Medicare Advantage plans, but not in all areas. If you are in an area where a Medicare Advantage plan is not available, your plan will enroll you in its Medicare coordination plan.

| Annual Costs | Group Health Medicare Plan | | Kaiser Permanente | UMP Classic |
|---|---|--|---|---|
| | Medicare Advantage | Original Medicare (coordinates with Medicare) | Senior Advantage | Medicare |
| | You pay | | You pay | You pay |
| Medical deductible | \$0 | \$250/person \$750/family | \$0 | \$250/person \$750/family |
| Medical out-of-pocket limit¹ (See separate prescription drug out-of-pocket limit for UMP Classic.) | \$2,500/person | \$2,000/person | \$1,500/person | \$2,500/person \$5,000/family |
| | Your copays and coinsurance for most covered services apply (except prescription drug costs). | Your medical deductible, copays, and coinsurance for all covered services apply. | Your copays and coinsurance for most covered services apply (except prescription drug costs). | Your medical deductible, copays, and coinsurance for most covered services apply. |
| Prescription drug deductible | None | None | None | \$100/person \$300/family (Tier 2 and 3 drugs only) |
| Prescription drug out-of-pocket limit¹ | None | Prescription copays and coinsurance apply to the medical out-of-pocket limit. | None | \$2,000/person Your prescription drug deductible and coinsurance for all covered prescription drugs apply. |

¹ Premiums, charges for services in excess of a benefit, charges in excess of the plan's allowed amount, coinsurance for out-of-network providers (UMP), and charges for non-covered services do not apply to out-of-pocket limits. Non-covered services include, but are not limited to, member costs above the vision and hearing aid hardware maximums.

| Benefits | Group Health Medicare Plan | | Kaiser Permanente | UMP Classic |
|---|---|--|-------------------|--|
| | Medicare Advantage | Original Medicare (coordinates with Medicare) | Senior Advantage | Medicare |
| | You pay | | You pay | You pay |
| Ambulance Air or ground, per trip | \$150 | 20% | \$50 | 20% |
| Diagnostic tests, laboratory, and x-rays | \$0 | \$0 MRI/CT/PET scan \$30 | \$0 | 15% |
| Durable medical equipment, supplies, and prosthetics | 20% | 20% | \$0 | 15% |
| Emergency room (copay waived if admitted) | \$65 | \$250 | \$50 | \$75 copay + 15% |
| Hearing Routine annual exam | \$20 | \$15 | \$30 | \$0 |
| Hardware | You pay any amount over \$800 every 36 months after deductible has been met for hearing aid and rental/repair combined. | | | |
| Hospital services Inpatient | \$200/day for the first 5 days, up to \$1,000 maximum/admission | \$150/day, up to \$750 maximum/admission | \$500/admission | \$200/day, up to \$600 maximum/admission + 15% professional fees |
| Outpatient | \$200 | \$150 | \$50 | 15% |
| Office visit Primary care | \$20 | \$15 | \$30 | 15% |
| Urgent care | \$20 | \$15 | \$35 | 15% |
| Specialist | \$20 | \$30 | \$30 | 15% |
| Mental health | \$20 | \$15 | \$30 | 15% |
| Chemotherapy | \$0 | \$15 | \$0 | 15% |
| Radiation | \$0 | \$30 | \$0 | 15% |
| Physical, occupational, and speech therapy | \$20 | \$15 (Per-visit cost for 60 visits/year combined) | \$30 | 15% |

| Benefits | Group Health Medicare Plan | | Kaiser Permanente | UMP Classic |
|--|---|--|-------------------|---|
| | Medicare Advantage | Original Medicare (coordinates with Medicare) | Senior Advantage | Medicare |
| | You pay | | You pay | You pay |
| Prescription drugs Retail pharmacy (up to a 30-day supply) — includes Medicare-approved diabetic disposable supplies | | | | |
| Value tier | Does not apply | \$5 | Does not apply | 5% (up to \$10/30-day supply) |
| Tier 1 | \$20 | \$20 | \$20 | 10% (up to \$25/30-day supply) |
| Tier 2 | \$40 | \$40 | \$40 | 30% (up to \$75/30-day supply) |
| Tier 3 | 50% up to \$250 | 50% up to \$250 | Does not apply | 50% |
| Mail order (up to a 90-day supply) | | | | |
| Value tier | Does not apply | \$10 | Does not apply | 5% (up to \$30/90-day supply) |
| Tier 1 | \$40 | \$40 | \$40 | 10% (up to \$75/90-day supply) |
| Tier 2 | \$80 | \$80 | \$80 | 30% (up to \$225/90-day supply) |
| Tier 3 | 50% up to \$750 | 50% up to \$750 | Does not apply | 50% (up to \$150 for specialty drugs; there is no per-prescription cost-limit for non-specialty Tier 3 drugs) |
| Preventive care | \$0 | \$0 | \$0 | \$0 |
| | See certificate of coverage or check with plan for full list of services. | | | |
| Spinal manipulations | \$20 | \$15 | \$20 | 15% |
| Vision care² Exam (annual) | \$20 | \$15 | \$30 | \$0 |
| Glasses and contact lenses | You pay any amount over \$150 every 24 months (or two calendar years for UMP) for frames, lenses, contacts, and fitting fees combined. Exception: For UMP Classic, you pay any amount over \$65 for contact lens fitting fees. | | | |

² Contact your plan about copays and limits for children's vision care.

See Outlines of Coverage sections for detail about all plans. This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan A available.

Basic Benefits included in all plans:

- **Hospitalization:** Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses:** Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require subscribers to pay a portion of Part B coinsurance or co-payments.
- **Blood:** First three pints of blood each year.
- **Hospice:** Part A coinsurance

| Plan A | Plan B | Plan C | Plan D | Plan F & Plan F* | Plan G | Plan K | Plan L | Plan M | Plan N |
|---|---|---|---|---|---|--|--|---|--|
| Basic benefits, including 100% Part B coinsurance | Basic benefits, including 100% Part B coinsurance | Basic benefits, including 100% Part B coinsurance | Basic benefits, including 100% Part B coinsurance | Basic benefits, including 100% Part B coinsurance | Basic benefits, including 100% Part B coinsurance | Hospitalization & preventive care paid at 100%; other basic benefits paid at 50% | Hospitalization & preventive care paid at 100%; other basic benefits paid at 75% | Basic benefits, including 100% Part B coinsurance | Basic including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER |
| | | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | 50% Skilled Nursing Facility Coinsurance | 75% Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance |
| | Part A Deductible | Part A Deductible | Part A Deductible | Part A Deductible | Part A Deductible | 50% Part A Deductible | 75% Part A Deductible | 50% Part A Deductible | Part A Deductible |
| | | Part B Deductible | | Part B Deductible | | | | | |
| | | | | Part B Excess (100%) | Part B Excess (100%) | | | | |
| | | Foreign Travel Emergency | Foreign Travel Emergency | Foreign Travel Emergency | Foreign Travel Emergency | | | Foreign Travel Emergency | Foreign Travel Emergency |
| | | | | | | Out of pocket limit \$4,940 paid at 100% after limit reached | Out of pocket limit \$2,470 paid at 100% after limit reached | | |

*Plan F also has an option called High Deductible Plan F. This high deductible plan pays the same benefits as plan F after one has paid a calendar year \$2,180 deductible. Benefits from High Deductible Plan F will not begin until the out-of-pocket expenses exceed \$2,180. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the contract. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

Washington State Health Care Authority
SUBSCRIPTION CHARGES AND PAYMENT INFORMATION
(Rates effective January 1, 2015)

Eligible By Reason Of Age Subscription Charges - Per Month

| | | | |
|---------------------|----------------------------------|-----------------------|------------------------------------|
| PEBB Retiree | PEBB Retiree & Spouse | State Resident | State Resident & Spouse |
| Plan F \$110.08 | Plan F \$213.91 | Plan F \$207.66 | Plan F \$415.32 |

Eligible By Reason Of Disability Subscription Charges - Per Month

| | | | |
|---------------------|----------------------------------|-----------------------|------------------------------------|
| PEBB Retiree | PEBB Retiree & Spouse | State Resident | State Resident & Spouse |
| Plan F \$209.26 | Plan F \$412.27 | Plan F \$353.01 | Plan F \$706.02 |

Please Note: The subscription charge amount charged is the same for all plan subscribers with certificates like yours. However, the actual amount a plan subscriber pays can vary depending on if and how much the group contributes toward a particular class of subscribers' subscription charges.

SUBSCRIPTION CHARGE INFORMATION

We (Premera) can only raise your subscription charges if we raise the subscription charges for all certificates like yours in this state.

DISCLOSURES

Use this outline to compare benefits and subscription charges among plans.

READ YOUR CERTIFICATE VERY CAREFULLY

This is only an outline describing your certificate's most important features. The Group policy is the insurance contract. You must read the certificate itself to understand all of the rights and duties of both you and your Medicare supplement carrier.

RIGHT TO RETURN CERTIFICATE

If you find that you are not satisfied with your certificate, you may return it to 7001 220th St. S.W., Mountlake Terrace, Washington 98043-2124. If you send the certificate back to us within 30 days after you receive it, we will treat the certificate as if it had never been issued and all of your payments will be returned.

CERTIFICATE REPLACEMENT

If you are replacing another health insurance certificate, do *NOT* cancel it until you have actually received your new certificate and are sure you want to keep it.

NOTICE

This certificate may not fully cover all of your medical costs. Neither Premera nor its producers are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

Be sure to answer truthfully and completely all questions. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

F**PLAN F:
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD**

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

| SERVICES | MEDICARE PAYS | PLAN F PAYS | YOU PAY |
|---|--|------------------------------------|-----------|
| HOSPITALIZATION* | | | |
| Semi-private room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but \$1,260 | \$1,260 (Part A Deductible) | \$0 |
| 61st through 90th day | All but \$315 a day | \$315 a day | \$0 |
| 91st day and after: (while using 60 lifetime reserve days) | All but \$630 a day | \$630 a day | \$0 |
| Once lifetime reserve days are used: | \$0 | 100% of Medicare eligible expenses | \$0*** |
| • Additional 365 days | \$0 | \$0 | All costs |
| • Beyond the additional 365 days | \$0 | \$0 | All costs |
| SKILLED NURSING FACILITY CARE* | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | \$0 | \$0 |
| 21st through 100th day | All but \$157.50 a day | Up to \$157.50 a day | \$0 |
| 101st day and after | \$0 | \$0 | All costs |
| BLOOD | | | |
| First 3 pints | \$0 | 3 pints | \$0 |
| Additional amounts | 100% | \$0 | \$0 |
| HOSPICE CARE | | | |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited copayment / coinsurance for outpatient drugs and inpatient respite care | Medicare copayment / coinsurance | \$0 |

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the carrier stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the plan's Basic Benefits. During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F (continued):**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

* Once you have been billed \$147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN F PAYS | YOU PAY |
|---|---------------|---|--|
| MEDICAL EXPENSES | | | |
| In or out of the Hospital and Outpatient Hospital Treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. | | | |
| First \$147 of Medicare approved amounts* | \$0 | \$147 (Part B Deductible) | \$0 |
| Remainder of Medicare approved amounts | Generally 80% | Generally 20% | \$0 |
| Part B Excess Charges (above Medicare approved amounts) | \$0 | 100% | \$0 |
| BLOOD | | | |
| First 3 pints | \$0 | All costs | \$0 |
| Next \$147 of Medicare approved amounts* | \$0 | \$147 (Part B Deductible) | \$0 |
| Remainder of Medicare approved amounts | 80% | 20% | \$0 |
| CLINICAL LABORATORY SERVICES | | | |
| Tests for diagnostic services | 100% | \$0 | \$0 |
| MEDICARE (PARTS A & B) | | | |
| HOME HEALTH CARE - Medicare approved services | | | |
| Medically Necessary Skilled Care Services and Medical Supplies | 100% | \$0 | \$0 |
| Durable Medical Equipment | | | |
| First \$147 of Medicare approved amounts* | \$0 | \$147 (Part B Deductible) | \$0 |
| Remainder of Medicare approved amounts | 80% | 20% | \$0 |
| OTHER BENEFITS - NOT COVERED BY MEDICARE | | | |
| FOREIGN TRAVEL - Not covered by Medicare | | | |
| Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA | | | |
| First \$250 each calendar year | \$0 | \$0 | \$250 |
| Remainder of charges | \$0 | 80% to a lifetime maximum benefit of \$50,000 | 20% and amounts over the \$50,000 lifetime maximum |

Selecting a PEBB Dental Plan

You have three dental plans to choose from:

- DeltaCare (managed-care plan)
- Willamette Dental Group Plan (managed-care plan)
- Uniform Dental Plan (UDP) (preferred-provider plan)

How do DeltaCare and Willamette Dental Group plans work?

DeltaCare and Willamette Dental Group are managed-care plans. This means you must select and receive care from a primary care provider in that plan's network or, as needed, receive a referral from your provider to see a specialist. You may change providers within your selected plan's network any time during the year. DeltaCare is administered by Delta Dental of Washington, and its network is DeltaCare PEBB (Group 3100). Willamette Dental Group administers its own dental network.

These plans don't have an annual deductible, so you don't have to keep track of how much you have paid out of pocket before the plan begins covering benefits. And you pay a set amount (called a copay) when you receive dental services. DeltaCare and Willamette Dental Group also do not have an annual maximum that they pay for covered benefits (some specific exceptions apply).

How does Uniform Dental Plan work?

UDP is a preferred-provider organization (PPO) plan. With this plan, you choose any dental provider and can change providers at any time.

UDP is also administered by Delta Dental of Washington, and its network is Delta Dental PPO (Group 3000). When you see a network provider, your out-of-pocket expenses are generally lower than if you chose a provider who is not part of this network.

Under UDP you pay a percentage of the plan's allowed amount (called coinsurance) for dental services after you have met the annual deductible. UDP pays up to an annual maximum of \$1,750 for covered benefits for each enrolled family member, including preventive visits.

Before you select a plan or provider

1. Confirm that a specific provider is within a dental plan's network. The provider can tell you if his or her practice is "in-network" for your plan.
2. Call the dental plan's customer service (listed in the front of this booklet) or use their online provider directory to confirm whether the provider is in-network for your plan.
3. Make sure you correctly identify your dental plan's network. For example, mention PEBB Group 3000 if you want to enroll in UDP, or Group 3100 if you want to enroll in DeltaCare. (Willamette Dental Group does not use a group number.)
4. Confirm the selection you've made on your enrollment form before you submit it. Did you want a preferred-provider or a managed-care plan?

Note: Delta Dental of Washington administers both UDP and DeltaCare, but each plan offers different networks. How much you pay for services depends on the provider network for your dental plan.

(continued)

Dental Benefits Comparison

For information on specific benefits and exclusions, refer to the dental plan's certificate of coverage or contact the plan directly. A PPO refers to a preferred-provider organization (network).

| Annual Costs | Preferred-provider plan | Managed-care plans | |
|---|--|---------------------------|----------------------------|
| | Uniform Dental Plan (UDP) (Group 3000 Delta Dental PPO) | DeltaCare (Group 3100) | Willamette Dental Group |
| | You pay | You pay | |
| Deductible | \$50/person, \$150/family | None | |
| Plan maximum (See specific benefits maximums below.) | You pay amounts over \$1,750 | No general plan maximum | |

| Benefits | Preferred-provider plan | Managed-care plans | |
|--|---|--|----------------------------|
| | Uniform Dental Plan (UDP) (Group 3000 Delta Dental PPO) | DeltaCare (Group 3100) | Willamette Dental Group |
| | You pay after deductible | You pay | |
| Dentures | 50% PPO and out of state; 60% non-PPO | \$140 for complete upper or lower | |
| Root canals (endodontics) | 20% PPO and out of state; 30% non-PPO | \$100 to \$150 | |
| Nonsurgical TMJ | 30% of costs until plan has paid \$500 for PPO, out of state, or non-PPO; then any amount over \$500 in member's lifetime | DeltaCare: 30% of costs, then any amount after plan has paid \$1,000 per year, then any amount over \$5,000 in member's lifetime Willamette Dental Group: Any amount over \$1,000 per year and \$5,000 in member's lifetime | |
| Oral surgery | 20% PPO and out of state; 30% non-PPO | \$10 to \$50 to extract erupted teeth | |
| Orthodontia | 50% of costs until plan has paid \$1,750 for PPO, out of state, or non-PPO, then any amount over \$1,750 in member's lifetime | Up to \$1,500 copay per case | |
| Orthognathic surgery | 30% of costs until plan has paid \$5,000 for PPO, out of state, or non-PPO; then any amount over \$5,000 in member's lifetime | 30% of costs until plan has paid \$5,000; then any amount over \$5,000 in member's lifetime | |
| Treatment of gum disease (periodontic services) | 20% PPO and out of state; 30% non-PPO | \$15 to \$100 | |
| Preventive/diagnostic (deductible doesn't apply) | \$0 PPO; 10% out of state; 20% non-PPO | \$0 | |
| Restorative crowns | 50% PPO and out of state; 60% non-PPO | \$100 to \$175 | |
| Restorative fillings | 20% PPO and out of state; 30% non-PPO | \$10 to \$50 | |

Life Insurance

Can I purchase life insurance when I retire?

The PEBB Program provides life insurance to eligible members through ReliaStar Life Insurance Company. As a PEBB retiree, you may be eligible to purchase life insurance on a self-pay basis through the following options:

1. Portability Provision
2. Conversion of Life Insurance Provision
3. PEBB Retiree Term Life Insurance

Portability Provision

Under the Portability Provision of your PEBB employee life insurance, you can apply to continue your terminated employee Basic Life and Supplemental Life Insurance until age 70 if certain conditions are met. You may elect to decrease your coverage continued under the Portability Provision, but you will not be able to increase it.

The minimum amount of your life insurance that you can apply to continue under the Portability Provision is \$5,000. The approved amount will not exceed the lesser of five times your annual earnings or \$750,000.

You may also apply to continue your terminated Dependent Basic Life and your Spouse or Registered Domestic Partner Supplemental Life Insurance at the same time you apply to continue your own life insurance coverage under the Portability Provision. Dependent Life Insurance may only be continued if you (the subscriber) continue your life insurance. You may elect to decrease coverage you continue for your dependents under the Portability Provision but you will not be able to increase it.

To continue your and your dependent's life insurance under the Portability Provision, you must apply to ReliaStar Life Insurance **no later than 60 days** after the date your PEBB employee life insurance ends due to retirement.

If you and your dependents are not approved for coverage under the Portability Provision, you and your insured dependents may still be eligible for the Conversion of Life Insurance Provision.

Conversion of Life Insurance Provision

Retiring employees and their dependents may be entitled to convert their life insurance to an individual policy without evidence of insurability (proof of good health).

The amount of the individual policy will be equal to (or at your option, less than) the amount of life insurance you or your insured dependents had on the termination date of the policy you are converting.

You must apply to continue your coverage under the Conversion of Life Insurance Provision **no later than 60 days** after the date your PEBB employee life insurance ends due to retirement.

How do I get more information or apply for the Portability or Conversion option?

This section provides a brief description of Portability and Conversion insurance options. To apply for the Portability or Conversion Provision, contact your personnel, payroll, or benefits office to complete your initial application. Both you and your employer have sections to complete on the application. Once the application has been completed, mail it to:

ReliaStar Life Insurance Company
20 Washington Avenue South, Route 4-N
Minneapolis, MN 55440-0020

ReliaStar Life administers both the portability and conversion policies and will provide you with additional information and services once the application is received. You may contact ReliaStar directly at 1-866-689-6990.

PEBB Retiree Term Life Insurance

The PEBB Program offers retiree term life insurance to subscribers who meet the eligibility and procedural requirements defined in WAC 182-12-209. Eligibility is the same as for medical and dental plans, except retiree term life insurance is only available to those who:

- Meet the PEBB Program's retiree eligibility requirements and had life insurance through the PEBB Program as an employee; or

(continued)

Life Insurance

- Are retirees of an eligible employer group, Washington State school district or educational service district who had life insurance through the PEBB Program as active employees; **and**
- Are not on a waiver of premium due to disability.

Your dependents are not eligible for retiree term life insurance.

If you enroll in COBRA between the time you had PEBB employee coverage and the time you become eligible for PEBB retiree coverage, you cannot enroll in retiree term life insurance. The PEBB Program does not offer life insurance to COBRA enrollees and you cannot have a break in life insurance coverage.

If you become disabled after the effective date of this insurance, you must continue making premium payments to keep your insurance in force.

This plan covers death from any cause.

What amount of insurance can I buy?

The amount of insurance paid to your beneficiary is based on your age at the time of death, according to the following schedule:

| Age at death | Amount of insurance |
|---------------|---------------------|
| Under 65 | \$3,000 |
| 65 through 69 | \$2,100 |
| 70 and over | \$1,800 |

This insurance has no cash value.

How much is the premium?

The cost is \$7.78 per month, regardless of age. Rates are guaranteed until December 31, 2015.

How do I enroll?

Complete the *Retiree Coverage Election/Change* form to elect PEBB retiree term life insurance. The PEBB Program must receive the form **no later than 60 days** after your employer-paid coverage ends. If you enroll when eligible and pay premiums on time, insurance becomes effective on your retirement date.

Who can I name as my beneficiary?

You may name any beneficiary you wish when you complete the enrollment form. If you should die with no named living beneficiary, payment will be made to your survivors in this order:

1. Spouse or domestic partner
2. Children
3. Parents
4. Estate

If you are married and wish to name someone other than your spouse or domestic partner as beneficiary, or if you have special estate planning needs, you should seek legal and tax advice before naming a beneficiary on your *Retiree Coverage Election/Change* form.

How do my survivors file a claim?

If you die, your beneficiary should submit a certified death certificate as soon as possible to Voya Life Claims, P.O. Box 1548, Minneapolis, MN 55440-1548, or call them at 1-866-689-6990. Your beneficiary should also notify the PEBB Program of your death. We may share this information with the Department of Retirement Systems to better serve your survivors.

Where can I get the insurance certificate?

This is a brief summary of the retiree term life insurance plan. If you would like a copy of the complete insurance certificate, contact the PEBB Program at 1-800-200-1004 or P.O. Box 42684, Olympia, WA 98504-2684. This insurance is provided by ReliaStar Life Insurance Company, a member of the Voya Financial family of companies.

SmartHealth

SmartHealth, the state's voluntary wellness program for eligible PEBB subscribers, focuses on your health and well-being. This program helps you take steps to improve your health by participating in fun and engaging activities and to earn a wellness incentive.

If you meet the wellness incentive requirements, you may be eligible for:

- A one-time deposit of \$125 into your health savings account in January 2016.
- OR
- If enrolled in a Classic or Value medical plan, you could earn a \$125 reduction in your annual medical deductible when you (the subscriber) receive covered services.

Who is eligible to participate?

PEBB medical plan subscribers who are not enrolled in Medicare Part A and Part B may participate in this wellness program. Eligible subscribers and their spouses or registered domestic partners enrolled in PEBB medical coverage can participate in activities through the new SmartHealth website; however, only the subscriber can earn the \$125 incentive.

How can SmartHealth help me?

SmartHealth is centered around an online experience that provides easy-to-use, interactive tools. You can find out where you are on your fitness journey and set goals for where you want to go. Participate in healthier activities while SmartHealth helps track your progress. With SmartHealth, you can participate in activities to improve your fitness, nutrition, and stress management — even your financial health. It starts with taking a well-being assessment to help customize your wellness experience. From there, you can jump straight into activities that interest you.

SmartHealth also rewards you for taking advantage of your health plan benefits — such as checkups and immunizations — at little or no cost to you. It's a good practice that can lead to better health and peace of mind.

How can I earn a wellness incentive?

If you are eligible, you can register at www.smarthealth.hca.wa.gov starting January 1, 2015 to participate in the SmartHealth program.

To qualify for a PEBB wellness incentive in 2016, you must complete the program requirements shown within timelines below:

| I am enrolled in PEBB medical coverage effective: | What activities do I need to complete to earn the wellness incentive? | When is the deadline to complete these activities? |
|---|---|---|
| January 1–April 1, 2015 with no break in coverage | Well-being assessment (800 points) Wellness activities (1,200 points) TOTAL: 2,000 points | June 30, 2015 |
| January 1–April 1, 2015 with a break in coverage | Well-being assessment (800 points) Log on to SmartHealth website (1,000 points) Join first activity (200 points) TOTAL: 2,000 points | Within 120 days of effective date of PEBB medical coverage; unless coverage begins October 1 or later, then criteria must be met no later than December 31, 2015) |
| April 2–December 1, 2015 with or without a break in coverage | Well-being assessment (800 points) Log on to SmartHealth website (1,200 points) TOTAL: 2,000 points | Within 120 days of effective date of PEBB medical coverage; unless coverage begins October 1 or later, then criteria must be met no later than December 31, 2015) |

(continued)

You must meet the two criteria below both when you complete the required activities **and** when the incentive is distributed in 2016:

- You are enrolled in a PEBB medical plan.

AND

- You are not enrolled in Medicare Part A and Part B.

A PEBB wellness incentive will only be provided if funds are approved by the Legislature for a PEBB wellness program or wellness incentives, or both.

Auto and Home Insurance

The PEBB Program offers voluntary group auto and home insurance through its alliance with Liberty Mutual Insurance Company — one of the largest property and casualty insurance providers in the country.

What does Liberty Mutual offer?

PEBB members may receive a group discount of up to 12 percent off Liberty Mutual's auto and home insurance rates. In addition to the discount, Liberty Mutual also offers:

- **Discounts** based on your driving record, age, auto safety features, and more.
- **A 12-month guarantee** on competitive rates.
- **Convenient payment options** — including automatic payroll deduction (for employees), electronic funds transfer (EFT), or direct billing at home.
- **Prompt claims service** with access to local representatives.

When can I enroll?

You can choose to enroll in auto and home insurance coverage at any time.

How do I enroll?

To request a quote for auto or home insurance, you can contact Liberty Mutual one of three ways (be sure to have your current policy handy):

- Visit PEBB's website at www.hca.wa.gov/pebb/Pages/auto_home.aspx
- Call Liberty Mutual at 1-800-706-5525. Be sure to mention that you are a State of Washington PEBB member (client #8246).
- Call or visit one of the local offices (see box).

If you are already a Liberty Mutual policyholder and would like to save with Group Savings Plus, just call one of the local offices to find out how they can convert your policy at your next renewal.

Note: Liberty Mutual does not guarantee the lowest rate to all PEBB members; rates are based on underwriting for each individual and not all participants may qualify. Discounts and savings are available where state laws and regulations allow, and may vary by state.

Contact a local Liberty Mutual office (mention client #8246):

| | |
|---------------------------|---|
| Federal Way | 1-800-826-9183 33915 1st Way S., Suite 203 Federal Way, WA 98003 |
| Redmond | 1-800-253-5602 15809 Bear Creek Parkway #120 Redmond, WA 98052 |
| Spokane | 1-800-208-3044 16201 E. Indiana Ave., Suite 2280 Spokane, WA 99206 |
| Tukwila | 1-800-922-7013 14900 Interurban Ave., Suite 142 Tukwila, WA 98168 |
| Tumwater | 1-800-319-6523 300 Deschutes Way SW, Suite 210 Tumwater, WA 98501 |
| Portland, OR | 1-800-248-8320 650 NE Holladay St., 2nd Floor Portland, OR 97232 |
| Outside Washington | 1-800-706-5525 |

Valid Dependent Verification Documents

For retirees not enrolled in Medicare Part A and Part B, and any subscriber enrolling a registered domestic partner:

Use the list below to determine which verification document(s) to submit with your enrollment form. You may submit one copy of your tax return if it includes all family members that require verification, such as your spouse and children.

You must submit all documents in English. Documents written in a foreign language must include a translated copy prepared by a professional translator and certified by a notary public.

Copy of document(s) needed if enrolling a spouse (choose one option):

- The most recent year's *1040 Married Filing Jointly* federal tax return that lists the spouse (black out financial information and you may black out dependents' Social Security numbers)
- The subscriber's and spouse's most recent *1040 Married Filing Separately* federal tax return (black out financial information and you may black out dependents' Social Security numbers)
- Proof of common residence (for example, a utility bill) and marriage certificate*
- Proof of financial interdependency (for example, a bank statement — black out financial information) and marriage certificate*
- Petition for dissolution of marriage (divorce)
- Legal separation notice
- Defense Enrollment Eligibility Reporting System (DEERS) registration

Copy of document(s) needed if enrolling based on a registered domestic partnership or legal union (choose one option):

- Proof of common residence (for example, a utility bill) and certificate/card of state-registered domestic partnership or legal union*

- Proof of financial interdependency (for example, a bank statement — black out financial information) and certificate/card of state-registered domestic partnership or legal union*
- Petition for invalidity (annulment) of domestic partnership or legal union
- Petition for dissolution of domestic partnership or legal union
- Legal separation notice of domestic partnership or legal union

Copy of document(s) needed if enrolling children (choose one option):

- The most recent year's federal tax return that includes the child(ren) as a dependent and listed as a son or daughter (black out financial information and you may black out dependents' Social Security numbers)
- Birth certificate (or hospital certificate with the child's footprints on it) showing the name of the parent who is the subscriber, the subscriber's spouse, or the subscriber's registered domestic partner**
- Certificate or decree of adoption
- Court-ordered parenting plan
- National Medical Support Notice
- Defense Enrollment Eligibility Reporting System (DEERS) registration

* If within two years of marriage, state-registered domestic partnership, or establishment of a legal union, then only the marriage certificate or certificate/card of state-registered domestic partnership or legal union is required.

** If the dependent is the subscriber's stepchild, the subscriber must also verify the spouse or registered domestic partner to enroll the child, even if not enrolling the spouse or registered domestic partner in PEBB coverage.

Completing the Retiree Forms

Please use dark ink to complete the form(s).

New enrollment or enrolling after deferral

Step 1: Check the “2015 Medical Plans Available by County” section in this guide to find the plans available to you.

Step 2: Locate your plan choice in the table on the right and complete the appropriate form(s).

Step 3: Be sure to include all eligible family members you wish to enroll.

Changing enrollment

Step 1: If you’re changing medical or dental plans or adding family members to your coverage, fill out the *Retiree Coverage Election/Change* form (form A).

Step 2: If you are changing medical plans, check the “2015 Medical Plans Available by County” section in this guide to find the plans available to you.

Step 3: Locate your plan choice in the column on the right and complete the appropriate form(s).

If you are currently enrolled in a Medicare Advantage plan, and change to a plan that is not a Medicare Advantage plan, you will also need to complete a PEBB Medicare Advantage Plan Disenrollment Form (form D). you can download this form from www.hca.wa.gov/pebb or call the PEBB Program to request one.

Note: If you’re adding a registered domestic partner to your coverage and completing form C, he or she should fill out the “spouse” section. You must also provide copies of documents that prove eligibility for your domestic partner.

If you’re adding a registered domestic partner, or a domestic partner’s child to your coverage, you must also complete and submit the *Declaration of Tax Status* form. You can download this form from our website or call the PEBB Program to request one.

Mail your forms

Complete, sign, and date the form(s) and mail them to:

PEBB Program
Health Care Authority
P.O. Box 42684
Olympia, WA 98504-2684

If sending payment with your form(s), please enclose your check or money order and mail to:

Health Care Authority
P.O. Box 42695
Olympia, WA 98504-2695

Requirements

- If you or any covered dependents haven’t sent us a copy of your Medicare card(s), you must send it along with your form(s).
- If you are enrolling a registered domestic partner, you must provide documents that prove the domestic partner’s eligibility. If you have questions about the enrollment process, please call us at 1-800-200-1004.

| Use | to enroll in or make changes to these plans: |
|----------------------|--|
| Form A only | <ul style="list-style-type: none">• Group Health Classic, Medicare Plan (Original Medicare), or Value• Group Health Options, Inc. consumer-directed health plan (CDHP)• Kaiser Permanente Classic or CDHP• Uniform Medical Plan Classic or UMP CDHP |
| Forms A and C | <ul style="list-style-type: none">• Group Health Medicare Advantage• Kaiser Permanente Senior Advantage |
| Forms A and B | <ul style="list-style-type: none">• Medicare Supplement Plan F, administered by Premiera Blue Cross |

Enrollment Forms

2015 Retiree Coverage Election/Change form (form A)

http://www.hca.wa.gov/pebb/Documents/51-403F_2015.pdf

2015 Premium Surcharge Help Sheet

http://www.hca.wa.gov/pebb/Documents/surcharge_helpsheet_2015.pdf

Premera Blue Cross Group Medicare Supplement Enrollment Application (form B)

<http://www.hca.wa.gov/pebb/documents/premeraB.pdf>

Medicare Advantage Plan Election Form (form C)

<http://www.hca.wa.gov/pebb/Documents/51-576-2015.pdf>

Electronic Debit Service Agreement

<http://www.hca.wa.gov/pebb/Documents/42-450.pdf>